

Multinational Teamwork and Nurses: Are Nurses prepared for the Challenges of Glo- balisation?

Wilhelmina Anna van Vliet

Master's Thesis
Master Degree in Global Health Care
2017

MASTER'S THESIS	
Arcada	
Degree Programme:	Master Degree Program in Global Health Care
Identification number:	6006
Author:	Wilhelmina Anna van Vliet
Title:	Multinational Teamwork and Nurses: Are Nurses prepared for the Challenges of Globalisation?
Supervisor (Arcada):	Heikki Paakkonen, PhD, Principal Lecturer
Commissioned by:	Arcada University of Applied Science / GROW project
<p>Abstract:</p> <p>The purpose of this thesis is to investigate factors associated with nurses working in a multinational medical team in normal daily job, disaster relief or health mission. The aim is to collect data from literature and stakeholders interviews to identify the challenges of multinational teamwork and find possible ideas for nurse education that address these challenges.</p> <p>In the first part results of a short survey concerning increasing globalization in the healthcare sector, elements of teamwork in medical profession and multinational teamwork in business environment, aviation and astronautics and defence forces are presented.</p> <p>To find answers to the research questions a descriptive literature review with a systematic approach was combined with semi-structured stakeholders interviews. A configurative review method with scoping and snowball literature search and inductive qualitative content analysis was applied.</p> <p>Summative content analysis resulted in seven categories: multinational teamwork, cultural competence, cultural self-awareness, professional identity/competence, communication, respect and education/training. The results of literature review and interviews are combined in a process of "lines-of-argument-synthesis" to find comparative understanding and/or discrepancies.</p> <p>The collected data supports the view that there is a need for education in teamwork skills, communication skills and cultural competence for nurses working in multinational teams. However the discussion and conclusions also suggest that empiric study results with explicit data on failures and disappointments in multinational teamwork with facts and figures on causes and effects is not available. Empiric data on this subject would give valuable information on what is and isn't working in multinational teamwork and thus would provide insight of what precisely needs to be done to improve multinational teamwork and why.</p>	
Keywords:	multinational, teamwork, nurse, cultural competence, cultural self-awareness, professional identity, communication, respect, education
Number of pages:	77
Language:	English
Date of acceptance:	13.11.2017

CONTENTS

Preface

1	Introduction	6
2	Background	8
2.1	Global Variation in Nurses' Education	8
2.2	Nurses and Migration.....	10
2.3	Teamwork in Healthcare.....	12
2.4	Multinational Teamwork.....	13
2.4.1	<i>Business/Management Environment</i>	<i>14</i>
2.4.2	<i>Aviation and Astronautics</i>	<i>15</i>
2.4.3	<i>Defence Forces</i>	<i>17</i>
3	Purpose, Aim and Research Questions	20
4	Methodology	21
4.1	Literature Review.....	21
4.2	Semi-structured Interviews	22
4.3	Analysis	22
4.4	Summary of Methodology used on Collected Data.....	23
5	Literature Review and Interviews Process.....	24
5.1	Data Collection Criteria.....	24
5.2	Data Collection Literature Review	25
5.3	Data Collection Interviews	30
6	Ethical considerations.....	31
6.1	Limitations	33
7	Literature Review Results	35
7.1	Multinational Teamwork.....	35
7.2	Cultural Competence	36
7.3	Cultural Self-Awareness.....	37
7.4	Professional Identity/Competence	37
7.5	Communication.....	38
7.6	Respect	39
7.7	Education/training.....	40
7.8	Summary of Literature Review Results.....	42
8	Interview Results.....	43

8.1	Multinational Teamwork.....	43
8.2	Cultural Competence.....	47
8.3	Cultural Self-Awareness.....	48
8.4	Professional Identity/Competence.....	51
8.5	Communication.....	53
8.6	Respect.....	55
8.7	Education/training.....	56
8.8	Summary of Interview Results.....	58
9	Literature Review and Interviews Findings combined.....	59
10	Discussion and Conclusions.....	61
10.1	Discussion.....	61
10.2	Conclusions.....	64
	References.....	66
	Appendices.....	74
	Appendix 1. Thesis Agreement	
	Appendix 2. List of reviewed Articles	
	Appendix 3. Introduction Letter for Stakeholder Interview	

Figures

Figure 1.	Comparison of nursing education among different countries.....	10
Figure 2.	Foreign trained nurses in OECD countries.....	11
Figure 3.	The four C's.....	13
Figure 4.	The data Analysis Process.....	22
Figure 5.	Literature review data collection flowchart.....	27

Tables

Table 1.	Inclusion and Exclusion Criteria.....	24
Table 2.	Data search.....	25
Table 3.	Scoping results.....	26
Table 4.	Scoping process.....	26
Table 5.	Handpicked articles.....	26
Table 6.	Description of reviewed articles.....	28
Table 7.	Keyword/concept comparison literature review and stakeholder interviews.....	60

PREFACE

Multinational teamwork in health missions today is more than often the rule and not the exception. But also in normal daily life, multinational teamwork is on the rise due to globalization, migration and specialization.

The inspiration for the theme of this Master's Thesis developed from the author's extensive experience in working in multinational teams. The author's interest is in exploring if there are needs and possibilities for training nurses in multinational teamwork skills. And if so, are there strategies or training models possible already existing in other professional disciplines, that can be used in the nurses' education in order to prepare nurses for the multinational reality in their work environment at home or on health mission?

1 INTRODUCTION

Besides working for over ten years in countries being a non-native nurse professional, the author has been living life in close connection with disaster relief and emergency aid for nearly 15 years. Professional qualifications, more than five years working experience and good command of English language was at the start of this international career in 1989 seen as fulfilling the criteria for working abroad or going on a disaster relief health missions.

Many successes in multinational team work were witnessed. But not always was success achieved without struggle. More than once team members had to leave because of issues of professional competence, expectations of employer or employee and the demands of the job not matching. As these events are rather traumatizing for the team members and negatively influencing the outcome of the project at hand, it left the author contemplating if there would be solutions to prevent this from happening.

Medical profession is, according to literature, a cultural dependent profession. This and prevailing public attitude's (racism/stereotyping), cultural bias and personal characteristics are all elements that play a role in multinational teamwork. Is a nurse by nature compassionate and has this assumption lead to the conclusion that nurses don't need to train multinational teamwork skills? Could it be desirable during the selection process of health delegates to address multinational teamwork skills and/or is there a need to include multinational teamwork training nowadays in the general nurses' education program? What has literature to say about multinational teamwork? What have experienced health delegates to say about multinational teamwork? What are multinational teamwork skills in nursing profession?

The background will provide initial information on what is written about variety in nurse education, nurse migration and nurses in teamwork. The background is including information concerning non-medical disciplines as for example aeronautics, business world and defence forces and their vision on multinational teamwork.

The author wants to find out from the literature review what multinational teamwork challenges are and if there is literature concerning nurses' need to be educated on these skills or not.

The author will by means of interviewing three nurses who are working in different situations (disaster relief aid, development aid and working in multinational teamwork in a regular nursing job abroad) add insight on the needs and visions on what skills the nurse in today's multinational environment might need to develop according to expert opinion. Because the current location of the author is Finland, several times examples are purposely chosen from this country and the interviewed persons are all from Finland.

This master's thesis was commissioned by ARCADA's GROW- project (GROW: Good ethical decision making – Resilient safety – Ongoing reflection – Wise practice). The project is about innovative learning environments that can build bridges between theory and practice and are a synergy between ethics, patient safety and caring (ARCADA Patient Säkerhets- och Lärocenter (APSLC), GROW-file, unpublished data, 2013-2015).

2 BACKGROUND

This chapter provides an introduction and theoretical framework on matters of the global variation in nurses' education, migration, teamwork in healthcare and multinational teamwork in the corporate environment, aviation, aeronautics and defence forces.

2.1 Global Variation in Nurses' Education

In the year 2009, the World Health Organisation (WHO) published the report "Global standards for the initial education of professional nurses and midwives". The report describes that because of increased complexity in healthcare provision and an increasing number of health professionals at different levels and the need to ensure more equal access to healthcare, the need for global standards for the initial education of professional nurses and midwives has arisen. In many countries the level for initial nurse education is at secondary school level, other countries require a university level education. In this report is mentioned that to implement a global standard is challenging due to the existing varieties in current nurse education and depends on national health needs and policies. For those countries that don't provide university level nurse education yet, country specific strategies that take into account different entry points for the education, cultural beliefs and norms, prior learning, experience and progression options, can facilitate in the transition period (World Health Organisation, 2009).

The policy brief on regulation of health professions education from WHO describes in the report "Transforming and Scaling up Health Professional Education and Training" different elements in the regulation of health professionals that assist in ensuring health providers to receive quality education which leads to safe, competent and ethical care and maintaining competency throughout clinical careers. The elements are stated to be that under supervision of a Professional Regulator Council or Board, accreditation, licensure/registration and continuing professional development is providing competency development and maintenance. In many countries, especially low income countries the challenges to implement the above mentioned education elements, are considerable. Mentioned are the outdated regulatory systems and regulatory best practice acts are not

revised or missing altogether. Lack of resources and insufficient authority are additional problems for many regulating institutes (World Health Organisation, 2013).

In 1999 European ministers of education signed the Bologna Declaration. This was the start of working toward the European Higher Education Area and implementation of the European Qualifications Framework in education practise. The goal is to harmonise curricula and degree structures within the European Union (Bologna Declaration, 1999). The Directive of recognition of professional qualifications 2013/55/EC deals with health care professionals and states that there are still many national differences that need to be addressed.

The implementation of the Bologna Declaration is a slow and ongoing process. In the article “Competence areas of nursing students in Europe” published in 2013, it becomes clear that Europe is still lacking sufficient documentation on competence and skill level of nursing staff, which would assist in developing an assessment tool that could be used by educators and administrators and help harmonising nursing education (Kajander-Unkuri, Salminen, Saarikoski, Suhonen & Leino-Kilpi, 2013).

The article “Future challenges for nursing education – A European perspective” the differences in nursing education systems in Europe are evaluated. The article mentions challenges for developing cross-cultural collaboration, clinical learning environment, role of patients and teacher education. The need for cross-cultural research is identified (Salminen et al., 2010).

In the “review of nurse education and regulation in selected OECD countries”, the wide variation in nursing education entry level, education level and post-graduation specialisations options become quite clear (Robinson & Griffiths, 2007). And when looking at the post-graduation education it becomes even more deregulated as shown for example in the review “Country report: Advanced Practice Nursing (APN) in Finland” (Suutarla et al, n.d.).

The article “comparison of nursing education among different countries” is comparing the nurse education of China with e.g. USA, England and Australia and presents many

differences in the education. The table hereunder gives an impression of these differences (Deng F.F, 2015).

Characteristics of nursing education teaching among countries.

Items	The UK ^{8,9}	The USA	Australia	China
Course distribution	Many basic courses, few practical courses	Few basic courses, many humanities	Few in basic courses, many professional	Many basic courses, few courses in humanities
Highlights of the course	Prophylactic medicine	Prophylactic medicine courses	Humanities and life sciences courses	Clinical nursing
Teaching procedure	Theory-practice-professional theory-clinical practice	Child-adult -geriatric	Geriatric-adult-child	Base-theory-clinical practice
Teaching guiding ideology	Patient-centered holistic nursing	Patient-centered holistic nursing	Patient-centered holistic nursing	Courses-centered theory knowledge
Main teaching form	Multi-media	Multi-media and self-learning	Self-learning	Lecture
Main test form	Written	Written, professional accreditation	Written, professional accreditation	Written

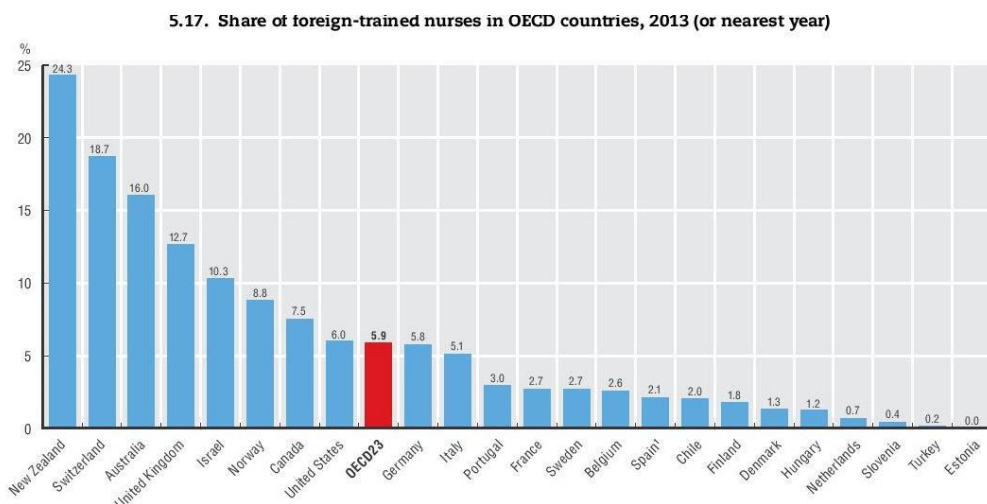
Figure 1, Comparison of nursing education among different countries (Deng F.F, 2015)

2.2 Nurses and Migration

As is written in the book “Nurses on the move” nurses are moving around in the world in quite big numbers for a variety of reason, like skill development or economic improvement. Many of the professional migration is organised by agencies that can match the skills required with the skills of the employee (Kingma, 2006).

“Migration Experiences of Foreign Educated Nurses: A Systematic Review of the Literature”, provides more insight in the reasons for migration. As Push Factors the authors mention: working conditions, lack of job opportunities, economic or political instability, spouse employment, escape from arranged marriage. Some countries (e.g. Philippines) have a culture of migration, nurses are a commodity of national export, the nursing education is started with the intention to migrate. Some of the Pull Factors that are mentioned are: better employment opportunities and higher salaries, learning a new language, new challenges and excitement of new experiences (Moyce, Lash & Leon Siantz, 2016)

The Organisation for Economic Co-operation and Development (OECD) has provided data concerning health work force of their member states. Figure 2 shows the share of foreign-trained nurses in OECD countries in 2013 (Health at a Glance, 2015).



1. Data for some regions in Spain relate to foreign nationality or country of birth, not the place of training.
 Source: OECD Health Statistics 2015, <http://dx.doi.org/10.1787/health-data-en>.


StatLink  <http://dx.doi.org/10.1787/888933280940>

Figure 2. Foreign trained nurses in EOOD Countries (Health at a Glance. 2015).

To give an example of numbers of nurses with foreign education, in 2014 more than 5600 nurses from Spain, 4000 nurses from Portugal and Romania and over 2500 nurses from Poland worked in the United Kingdom. These approximately 16 000 nurses represented 19% of the foreign educated nurses in the U.K. The total amount of foreign educated nurses is around 80.000, this being 12.7% of the nursing workforce in the U.K in 2014 (Health at a Glance, 2015).

Challenges that migrating nurses face are: Regulatory difficulties, language and communication, racism and discrimination, underutilization of skills, acculturation, differences in scope of nursing practice and family issues(Moyce et al., 2016).

Migration of nurses is influenced by the severe shortage globally of healthcare providers. In May 2010 the WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted by the 63rd World Health Assembly. This Code is providing a framework for cooperation and dialogue on the issue of International Recruitment of Health Personnel. The Member States are encouraged to follow ethical principles and standards when recruiting internationally. The concern is for developing countries with already weak health systems and shortages of health care providers (WHO, 2010).

2.3 Teamwork in Healthcare

As written in the article “Effective healthcare teams require effective team members: defining teamwork competencies”, teamwork is essential in today’s healthcare provision, no healthcare provider can deliver a complete episode of healthcare singlehanded (Leggat S.G, 2007).

A team can be defined as (quote) “*a small number of people with complementary skills who are committed to a common purpose, performance goals and approach for which they hold themselves mutually accountable*” (end quote) (Katzenbach & Smith, 1993).

There is according to literature a direct link between effective teamwork and the quality of patient care. Teamwork is not an automatic consequence of placing people together. Learning to work in a team should take place already early in the education of a healthcare professional. For enhanced teamwork and performance organisations should establish the requirements for their teams. Besides providing a meaningful task interdependency and task-relevant knowledge for the team members, organisations should establish the knowledge, skills and attitudes of the team members (what team members know, do and feel) to optimize the team performance. A healthcare team needs team members that can work together, communicate effectively, anticipate and meet other team member’s needs, shows and inspires confidence which results in a coordinated collective action (Lerner, Magrane & Friedman, 2009).

According the article “Collaboration, Credibility, Compassion and Coordination: Professional Nurse Communication Skill Set in Health Care Team Interactions” the nurse interaction skill in healthcare teamwork is understudied, but from the existing research it is shown that effective team communication is a vital aspect in reaching improved patient care. From the nurse in a healthcare team is often required to serve as link between other team member and e.g. patients and family. Good communication skills are essential to nursing practice. In figure 3 the findings of the above mentioned research is presented. The communication skill sets used by nurses are listed as the four C’s of professional nurse communication: Collaboration, Credibility, Compassion and Coordination (Apker, Propp, Zabava, Ford & Hofmeister, 2006).

The Four C's of Professional Nurse Communication in Health Care Team Interactions

Communication skill set	Representative behaviors
Collaboration	Solicit information and critique its completeness and veracity Organize, filter, and provide pertinent information to physicians and other team members Engage in dialogue with physicians to identify solutions to problems and participate in decision making
Credibility	Speak credibly, avoiding jargon or vague terminology Adjust communication to team member roles, personalities, and contexts Interact assertively and confront conflict directly yet respectfully
Compassion	Display consideration and caring for team member concerns Advocate for team member needs when warranted Show respect and affiliation verbally and nonverbally
Coordination	Assign responsibilities and organize team members Mentor residents, new nurses, or PCAs in patient care Encourage input from team members and make them feel that their contributions are valued

Figure 3. The four C's (Apker et.al, 2006)

One more important element of teamwork is presented in the article “Are teamwork and professional autonomy compatible, and do they result in improved hospital care?”, namely autonomy. Professional team work includes dependent, interdependent and independent elements. Nurses that experience a higher level of autonomy enjoy more job satisfaction, are more involved in decision making, rate the quality of provided care higher and work well with other team members (Rafferty, Ball & Aiken, 2001).

2.4 Multinational Teamwork

The globalisation process is a phenomenon that touches many aspects of the world we live in every day. Increased mobility of human kind, ever growing volume of trade around the world, exchange of knowledge, improved connectivity possibilities are just a few to name. Increased technology and developments in all areas of science are reasons for more and more specialisation of human resources. With these developments, multinational teamwork has become more and more a reality in a wide variety of subjects. The author selected three different environments to look at, based on the idea that these sectors have a clear self interest in success either for financial reasons or safety reasons or both. Defence forces and aviation were chosen as the author had prior knowledge of their involvement in multinational teamwork. Also in working life the author has been made aware of models used in aviation that are introduced in the medical environment (e.g. the surgical safety checklist). The choice of business/management environment wasn't considered by the author beforehand. This choice was made after articles from

this environment presented themselves in the search for information on multinational teamwork and provided interesting information.

2.4.1 Business/management environment

Failure in overseas assignment of managers in international business causes significant cost for firms. Costs stem from replacement of the manager, lost opportunities, decline in productivity and possible damaged relationships with the overseas counterparts. Besides adjustment failure of the expatriate personally, failures can be linked with insufficient understanding of the local political and sociocultural environment. The interest of the (international) business community in finding solutions for the failures is understandable (Johnson, Lenartowicz & Apud, 2006).

The lack of cross-cultural competence has often been determined to be the main factor of failures in international business. Reasons for the lack of cross-cultural competence in managers are according to research due to inadequate preparation for the international business world and inability of the managers to understand neither the local culture nor being able to interact effectively with the foreign counterparts. Factors mentioned that are requirements for cross-cultural competence are: attitude, awareness, knowledge and skills. Personality factors can affect the learning outcome of cross-cultural competence, e.g. the ability to act on the change of cultural boundaries. Sufficient cultural knowledge provides opportunities for reducing misunderstandings when interacting with persons from another culture (Johnson et al., 2006).

The proposed definition for cross-cultural competence in the international business field is given (quote) *“Cross-cultural competence in international business is an individual’s effectiveness in drawing upon a set of knowledge, skills and personal attributes in order to work successfully with people from different national cultural backgrounds at home or abroad”* (end quote) (Johnson et al., 2006).

Individual ethnocentrism or institutional ethnocentrism will most likely affect the relationships with local counterparts and work environment negatively. Also the “cultural

distance”, in other words the differences between own culture and overseas culture, affects the cross-cultural competence outcome (Johnson et al., 2006).

The Essential Guide to Leadership, published by The Harvard Business Review, published the article “Managing Multicultural Teams”. It handles the issue of conflict in a multinational team. Four categories are identified as possible sources for conflict:

- Direct vs. indirect communication (direct and explicit vs. embedded in the message)
- Misunderstanding or frustration due to language use (accent, fluency, translation problems)
- Different attitudes towards hierarchy and authority (hierarchical culture vs. egalitarian culture)
- Conflicting norms for decision making

And four strategies are offered in this article:

- Adaptation (working around the cultural gaps)
- Structural intervention (reorganizing the team)
- Managerial intervention (implementation of norms and supervision thereof)
- Exit (removing a team member)

(Brett, Behfar & Kern, 2006)

The author of the above mentioned article Jeanne Brett, was interviewed after the publication of this article and asked what would be her advice to IT managers of multicultural teams. Her answer was (quote) “*The most fundamental thing is to be a role model for respect. It rubs off on the other members of the team. Helping team members see that problems are due to cultural differences and not personality helps a lot*” (end quote) (Melymuka, 2006).

2.4.2 Aviation and Astronautics

The aviation sector is a fast growing industry. To keep up with the demands airline companies are expanding and merging, which results in personnel from different nationalities working closely together. This is also the case for cockpit crew. Aviation

safety is depending on teamwork and communication skills, the majority of accidents in aviation are caused by miscommunication (Alam, 2015).

Teamwork in cockpit is influenced by “power distance” (this cultural aspect indicates human inequality in distribution of power and authority) and interdependence. Low power distance provides an environment where the working relationship in the team resembles democracy and is facilitating communication. High power distance on the other hand reflects a more autocratic management style and is inhibiting communication. Power distance is one cultural factor that has been identified as source of suboptimal pilot performance. Acknowledging of interdependence creates the ground for success in collaboration. Standardisation of procedures has proven to be an effective strategy to reduce cultural differences and promoting teamwork (Alam, 2015).

Also in astronautics the work environment is becoming more and more multicultural. Space crews are relatively small (3-6 people), living in a confined and isolated space for often long duration. A significant difference between space crew teams and teams on earth is that in case of team related problems, the option of early “exit” is not available in case of a dysfunctional team. A dysfunctional team is a serious threat to reaching the goals of the mission. Effective functioning of a multicultural team can be defined as (quote) “*the ability to live and work successfully in another culture*” (end quote). Any international mission requires adaptation of the person undertaking the assignment. The adaptation process is described as the “U” curve theory: initial stage of elation, followed by depression (culture shock or culture fatigue) and feeling of satisfaction. Recognition and coping strategy training should be trained pre-departure (Kealey, 2004).

In multinational teams, when there are some team members that share the same culture, which creates a “dominant group” there is the possibility of “in-group/out-group”, where individuals become isolated. This can negatively influence the performance of the team. Skills needed for working in another culture are: relationship building, respect, tolerance for ambiguity, flexibility, realistic expectations, initiative and self-confidence (Kealey, 2004).

For effective multicultural team work on earth but even more so in space crews, it would be desirable to have assessment tools that by cross-cultural collaboration provided common standards and procedures for selection, training and support of stakeholders (Kealey, 2004).

The article “A Proposal for the Integration of a Behavioural Research into International Space Station Operation” mentions the necessity of thorough understanding of human functioning within multinational crews in a highly technical environment in space stations. The aim for this research is to improve safety and efficiency and provide solid recommendations for the selection, training and support of space crews on a future mission to Mars. Areas of potential difficulties within the multinational crews are named as language and cultural related variations in behaviour e.g. individual vs. team functioning, styles of leadership, preference or dislike of proceduralization. The proposals for research methodology is mentioning observation in space station, simulations, interviews, surveys and confidential incident reporting (Musson, 2000).

2.4.3 Defence Forces

There is a variety of literature on how the multinational factor is part of defence forces work environment. Defence forces can be operating in combat as allied forces or for example collaborate in peacekeeping as joined forces (e.g. NATO). Armed forces operate in a variety of different circumstance with different multinational /cross cultural structures, within a team, or teams of different nationalities combined in one operation or a team embedded in another culture (Vliet & Amelsfoort, 2005).

The report “Leader and team adaptability in multinational coalitions (LTAMC): An international research project” of the 10th international command and control research and technology symposium, describes the need and tools for research to advance the development of adaptive performance in multinational coalitions. Primary focus is the impact of culture on the teamwork for multicultural teams in Command and Control functions. The research group will conduct national and multinational experiments to develop science in the area of adaptability, with the goal to identify products that partic-

icipating nations can use to improve leader and team adaptability in multicultural environment (Sutton & Edelman, 2005).

A variety of tests that was included in this research are described in this article. Simulation exercises during which data on cultural dimensions, cognitive styles, personality and organisational issues were collected. The “off the shelf” computer game (Neverwinter Nights™) was used to build a test environment to build a baseline of responses from homogenous military teams. Also very interesting is the mentioning of the Globesmart tool, an instrument to perform a self-assessment profile (SAP). I quote *“Individuals using Globesmart® complete the SAP, after which the program plots a personal profile for the individual along the six dimensions. For example, the tool will plot to what degree the individual is independent, has an egalitarian relationship pattern, is risk tolerant, has a direct communication style, is task-oriented, and is short-term oriented. Individuals can compare their own personal profiles with the average profile for any of the countries in the Globesmart® database.”* (end quote) (Sutton & Edelman, 2005)

“Training Multinational Medical Teams for Deployment” is a publication of the Medical Corps International, an international platform for Military Medicine. In this publication the need for training is stressed, especially with the current trend of multinational teamwork. Challenges mentioned are differences in operating procedures, technical incompatibilities and lack of standardisation, procedural and tactical differences, language barriers, variation in professional relationships between nations and differences in medical command structures between nations. The aspects trained in simulation are; communication, collaboration and team based problem solving (Medical Corps International Forum, 2011).

The paper of NATO “Chapter 4 – Multinational Military teams” repeats many of the findings already mentioned in the text here above. Where it stands apart is in mentioning more explicit ethnocentrism (mainly from the western countries towards people from “Third World”), marginalization and ostracism, based on racial, cultural or religious lines. Often when this appears, the roots can be found in ignorance. Another cause for tension can be found in differences in ethical views, e.g. participating of UN forces in the black market (Vliet & Edelman, 2005).

Loyalty is very highly valued in military; group allegiance is seen to be essential to combat effectiveness. The intensive efforts of the UN to activate developing countries to participate in UN operation has created challenges to form truly integrated teams since when loyalty is directed towards the primary group the team might not be effective in reaching the goals of a mission (Vliet & Edelman, 2005).

3 PURPOSE, AIM AND RESEARCH QUESTIONS

The purpose of the project is to investigate factors associated with nurses working in a multinational team in normal daily job, disaster aid or health mission.

The aim is to collect data from literature and by interviews from which awareness for the possible need of multinational teamwork education could arise and ideas for nurse education on multinational teamwork can be constructed.

The research questions to be addressed:

- What are the challenges of multi-national teamwork for nurses?
- Is there a need for specific education on the subject of multinational teamwork for nurses?

4 METHODOLOGY

The aim of this study is to investigate factors associated with nurses working in a multinational team in normal daily job, in disaster aid or health mission and examine if there is a possible need for education for nurses on multinational teamwork. Preliminary literature data searches were conducted during October 2016 – December 2016, the literature review data collection took place in April 2017 – June 2017. Three interviews with stakeholders were conducted during June 2017- July 2017.

4.1 Literature Review

As written in the article “Clarifying differences between review designs and methods” new approaches develop all the time and there is a great overlap of approaches, therefore it is not easy to label the different methods (Gough, Thomas, & Oliver, 2012). This thesis is combining descriptive literature review and semi-structured interviews. It can be seen as a configurative review method, with scoping and snowball literature search method and semi-structured interviews with qualitative content analysis.

Descriptive literature review provides information or describes attitudes towards an issue in order to find out what is prevalent towards the issue (Kumar, 2005). A systematic approach was implemented; inclusion and exclusion criteria’s were applied and the search is described in detail and repeatable (Aveyard, 2014).

Configurative refers to data collecting that seeks to interpret and arrange information to develop concepts. This method is used when the review intends to inform and provide knowledge that may lead to concepts. Configurative review seeks to find patterns in heterogeneity (Gough et al, 2012).

Scoping literature search is non-systematic, rather breadth of coverage than in-depth. It allows the researcher the use of research and non-research material in the review (Rumrill, Fitzgerald, & Merchant, 2010). Or, as written in the article “What are the most common domains of the core competencies of disaster nursing? A scoping review”, a

scoping review is concentrating on what is known about a topic in the existing literature (Al Thobaity, Plummer, & Williams, 2016).

Snowballing refers to a method where references of references are used for the review. By doing this there might be literature found that didn't appear in predefined protocol driven data-base searches (Greenhalg & Peacock, 2005).

4.2 Semi-structured Interviews

Interviews, compared to questionnaires, provide more opportunity to obtain in-depth information and react to observations of non-verbal reactions. Semi-structured interviews are characterized by flexibility, freedom of wording and order decided by the interviewer. Narrative technique is a tool usable for collecting data that is of a sensitive nature (Kumar, 2005).

4.3 Analysis

(quote)“*Data analysis – application of one or techniques to a set of data for the purpose of discovering trends, differences or similarities. The type of techniques is guided by the subject matter of the problem*” (end quote) (Phillips,1986: Clamp, Gough, & Land, 2005). The steps followed in the qualitative analysis are documentation, categorizing, understanding and reporting (Flick, 2009).

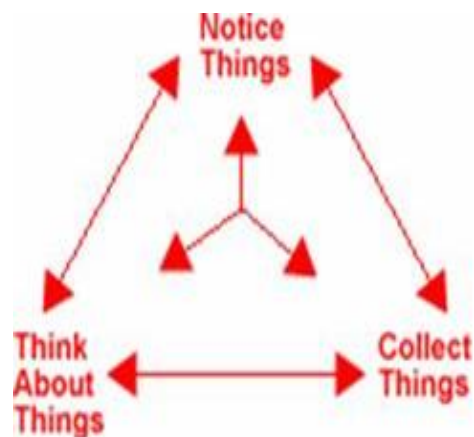


Figure 4. The Data Analysis Process (Seidel 1998)

The qualitative content analysis process has the following characteristics; iterative and progressive (a repeating cycle of thinking, noticing and collecting), recursive (by progressing forward being compelled to revisit earlier material) and holographic (each step includes all elements) (Seidel, 1998).

4.4 Summary of Methodology used on Collected Data

The main phases for this thesis were: preparation, data collecting and selecting, analysing and organizing of data and reporting of findings. The “Checklist for Researchers Attempting to Improve the Trustworthiness of a Content Analysis Study” provided guidance in the data selection process and organisation phase (Elo et al., 2014).

For this thesis the process of inductive qualitative content analysis was chosen. The literature search revealed that the knowledge of the phenomenon of multinational teamwork for nurses is fragmented, therefore inductive analysis is the recommended approach (Elo & Kyngäs, 2008).

The author repeatedly read through the collected data in the process of grouping and categorizing. Summative content analysis resulted in identification of content-characteristic words. The content-characteristic words were placed in sub-categories, which then were eventually brought together in main categories (Elo & Kyngäs, 2008; Polit & Beck, 2004; Hsieh & Shannon, 2005). The same main categories identified from the literature review were applied on the interview data.

The results from the literature review and interviews were combined to find “comparative understanding” or “comparative discrepancies”. This process of “lines-of-argument synthesis” intends to form a “whole” of separate parts and intends to provide a result that is greater than the sum of the parts (Barnett-Page & Thomas, 2009).

5 LITERATURE REVIEW AND INTERVIEWS PROCESS

5.1 Data Collection Criteria

Table 1. Inclusion and Exclusion Criteria

<i>Inclusion</i>	<i>Exclusion</i>
Research or expert article	Other type of articles and literature
Peer-reviewed	Not reviewed
English language	Other languages than English
Published after 2000	Published before 2000
Full text article availability	Full text not available
Closely related to the research questions	Not closely related to the research questions
Maximum variation sampling /representativeness of all aspects of the topic	Repetitive of topic after saturation (taking into consideration the length of Masters Thesis).

Due to the low search results on multinational teamwork and nurses articles “closely related to the research questions” were included. The selected articles (n=4) dealt with interprofessional teamwork and as the author learned from the data search the challenges in interprofessional teamwork are comparable to the challenges in multinational teamwork and the articles had added value. Three of the selected articles were scoped from an article that related directly to the research question. Another “closely related to the research question” inclusion concerned articles that from the title seemed not to deal with nurses, but then in the text there was sufficient material that was related to nurses.

As the purpose of the thesis was investigating factors associated with nurses working in a multinational team in normal daily job, disaster aid or health mission, and possible education needs, the author made efforts to equally represent the mentioned areas in the selected articles (maximum variation sampling). Therefore the most valuable articles were chosen; normal daily job (n=3), disaster aid (n=3) and humanitarian aid/health mission (n=4) and education (n=2).

5.2 Data Collection Literature

Table 2. Database search

<i>Database</i>	<i>Hits</i>	<i>Articles based on Title</i>	<i>Articles based on Abstract</i>	<i>Articles based on Full Text</i>	<i>Articles based on References</i>
EBSCO / CINAHL full text/Communication and mass media complete	231	45	30	5	5
PubMed	50	27	14	3	1
Handpicked				2	

The selection of the search words and databases was an intensive process, the author made sure that the inclusion and exclusion criteria's were respected. Especially the inclusion criteria of full text availability proved to be challenging. The data collection is transparent, described in detail and tested by the author to be repeatable.

Search words used in EBSCO + CINAHL + Communication and mass media complete: multinational (TX) AND international (TX) AND teamwork (TX) AND nurse AND aid AND disaster AND education. Search words used in PubMed: international AND nurse AND humanitarian OR teamwork/collaboration AND Humans [Mesh] OR education/curriculum AND Humans [Mesh]

The search in EBSCO + CINAHLfull text + Communication and mass media complete did not provide articles for the topic medical mission/humanitarian aid; therefor the search was extended to PubMed. There was a need to define teamwork and education more precise, as the amount of articles without this provided too many hits and too many not relevant articles.

Table 3. Scoping results

Database search article	Article based on References
Humanitarian Nursing in Developing Countries: A Phenomenological Analysis	- Ethics beyond borders: How health professionals experience ethics in humanitarian assistance and development work
Cultural view of nursing in Saudi Arabia*	- Perception of clinical safety climate of the multicultural nursing workforce in Saudi Arabia: A cross-sectional survey* - Understanding Cultural Competence in a Multicultural Nursing Workforce: Registered Nurses' Experience in Saudi Arabia*
Interprofessional non-technical skills for surgeons in disaster response: A qualitative study of the Australian perspective	- Healthcare worker competencies for disaster training - The Effects of Intrapersonal, Intragroup, and Intergroup Conflict on Team Performance Effectiveness and Work Satisfaction - Role understanding and effective communication as core competencies for collaborative practice

*The reference scoped/snowballed from the article “Cultural view of nursing in Saudi Arabia” was the article “A multicultural nursing workforce and cultural perspectives in Saudi Arabia”, however full text was not available. The articles “Perception of clinical safety climate of the multicultural nursing workforce in Saudi Arabia: A cross-sectional survey” and “Understanding Cultural Competence in a Multicultural Nursing Workforce: Registered Nurses’ Experience in Saudi Arabia” were presented instead on the database and found useful by the author. To provide maximum variation sampling, scoping was used to equally represent the different aspects of the aim of the thesis.

Table 4. Scoping process

Scoping process	
References (5 articles)	212
Abstracts	23
Not available in full text	12
Articles selected	6

Table 5. Handpicked articles

Handpicked articles
Cultural Competence in Baccalaureate Nursing Education
Identifying Global Health Competencies to Prepare 21st Century Global Health Professionals: Report from the Global Health Competency Subcommittee of the Consortium of Universities for Global Health

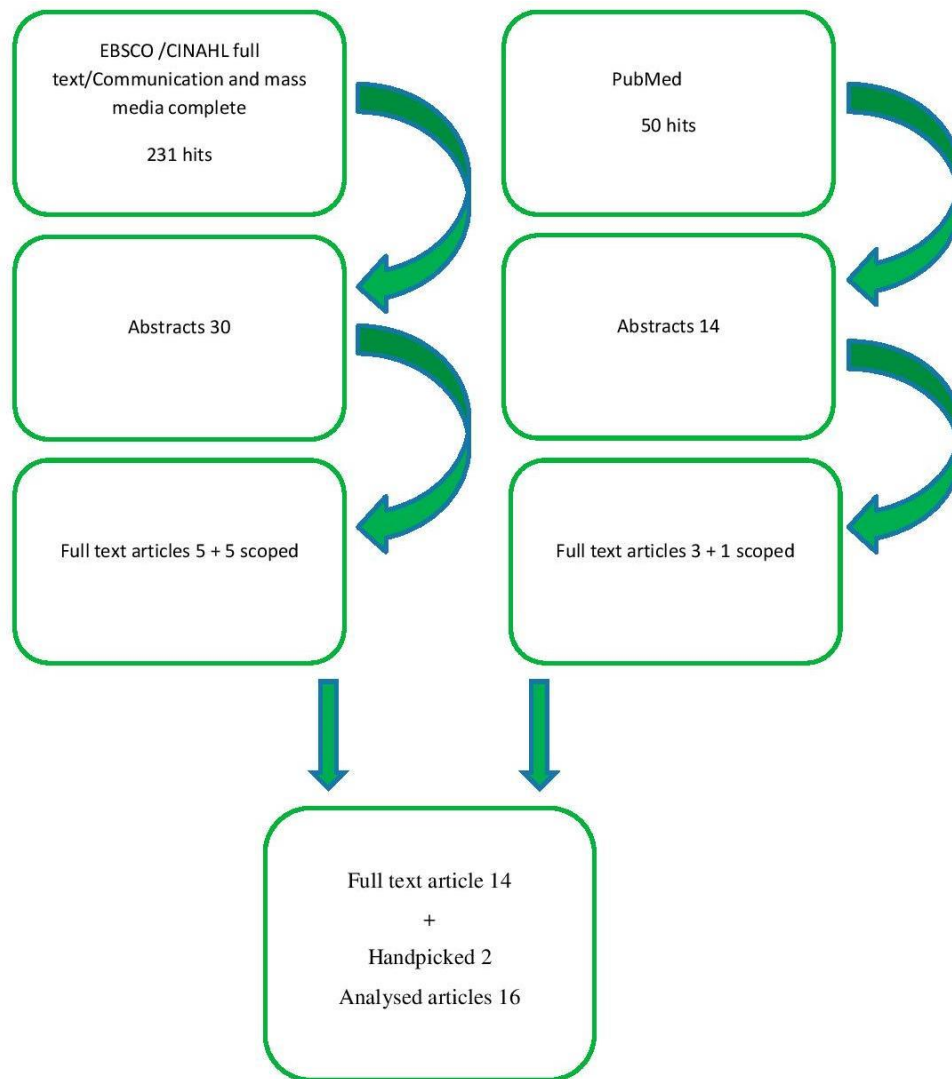


Figure 5. Literature review data collecting flowchart

After reading, selecting and analysing the articles the author noticed several recurrent themes in the articles. The results of the literature review are presented in this thesis according to the observed keynotes. The emerging subjects were identified as:

- Multinational teamwork
- Cultural Competence
- Cultural Self-awareness
- Professional Identity / Competence
- Communication
- Respect
- Education / Training

Table 6. Description of reviewed articles

	<i>Authors, year, place /publication</i>	<i>Title</i>	<i>Method</i>	<i>Relevance</i>
1	Almutairi, A. F., Gardner, G., & McCarthy, A. 2013. Saudi Arabia – Australia / Collegian: The Australian Journal of Nursing Practice, Scholarship and Research, peer-reviewed	Perception of clinical safety climate of the multicultural nursing workforce in Saudi Arabia: A cross-sectional survey	Survey component of a larger mixed method case study	Multi-national teamwork, nurses, cultural competence, education.
2	Almutairi, A. F., McCarthy, A., & Gardner, G. E. 2015. Saudi Arabia –Australia – Canada / Journal of Transcultural Nursing, peer-reviewed	Understanding Cultural Competence in a Multicultural Nursing Workforce: Registered Nurses' Experience in Saudi Arabia	Semi-structured interviews, inductive analysis	Cultural competence, quality of healthcare, nurses, multinational teamwork, education, communication
3	Calvillo, E., Clark, L., Ballantyne, J. E., Pacquiaio, D., Purnell, L. D., & Villarruel, A. M. 2009. USA / Journal of Transcultural Nursing, peer-reviewed	Cultural Competence in Baccalaureate Nursing Education	Review, expert opinion, commentary	Education, nurses, cultural competence, professional competence, curriculum.
4	Chang, W. W. 2007. Taiwan / Adult Educational Quarterly, peer-reviewed	Cultural Competence of International Humanitarian Workers	Qualitative design, participatory observations, semi-structured interviews	Cultural competence, cross-cultural, cultural ability, education, curriculum
5	Chiu, Y. W., Weng, Y. H., Chen, C. F., Yang, C. Y., & Lee, M. L. 2014. Taiwan / Evaluation & the Health Profession, peer-reviewed	Perceptions and Efficiency of Short-Term Medical Aid Missions Among Key Groups of Health Professionals	Survey/Questionnaire,	Cultural awareness, professional competence, communication, education
6	Collin, K., Paloniemi, S., & Heranen, S. 2015. Finland / Studies in Continuing Education, peer-reviewed.	INPROF – promoting teamwork processes and interprofessional collaboration in emergency work (2010-2012)	Observations and interviews	Interprofessional collaboration, teamwork, communication, nurses, education
7	Cox, K. B. 2003. USA / Nurse Admin Quarterly, peer-reviewed	The Effects of Intrapersonal, Intragroup, and Intergroup Conflict on Team Performance Effectiveness and Work Satisfaction	Questionnaire	Teamwork, education
8	Felemban, E., O'Conner, M., McKenna, L. 2014. Saudi Arabia – Australia / Middle East Journal of Nursing, peer-reviewed	Cultural view of nursing in Saudi Arabia	Literature review	Cultural competence, conflict, multinational workforce, communication, education

	<i>Authors, year, place / publication</i>	<i>Title</i>	<i>Method</i>	<i>Relevance</i>
9	Hsu, E. B., Thomas, T. L., Bass, E. B., Whyne, D., Kelen, G. D., & Green, G. B. 2006. USA / BMC Medical Education, peer-reviewed	Healthcare worker competencies for disaster training	Evidence based consensus building, literature review, expert panel	Communication, multi-disciplinary training, standardisation, education
10	Hunt, R. 2008. Canada / Developing World Bioethics, peer-reviewed	Ethics beyond borders: How health professionals experience ethics in humanitarian assistance and development work	Interviews, phenomenology based framework	Ethics, professional competence, cultural competence, professional identity, training
11	Jumat, J. D., Bezuidenhout, M. C., & Neethling, T. G. 2014. South Africa / Curationis, peer reviewed	Pre-deployment preparation of military nurses of the South African National Defence Force for participation in peace support operations	Questionnaire, quantitative, exploratory	Training, teamwork, professional competence,
12	Lal, S., & Spence, D. 2016. New Zealand / Journal of Transcultural Nursing, peer-reviewed	Humanitarian Nursing in Developing Countries: A Phenomenological Analysis	Conversational interviews, descriptive	Multinational, cultural values, ethics, collaboration, global health education
13	Noguchi, N., Inoue, S., Shimano, C., Shibayama, K., & Shinchi, K. 2016. Japan / Open Access Journal, peer-reviewed	Factors Associated with Nursing Activities in Humanitarian Aid and Disaster Relief	Questionnaire, evaluation, logistic regression analysis	Training, nurses, professional competence, curriculum
14	Suter, E., Arndt, J., Arthur, N., Parboosingh, J., Taylor, E., & Deutschlander, S. 2009. Canada / Journal of Interprofessional Care, peer-reviewed	Role understanding and effective communication as core competencies for collaborative practice	Qualitative, interviews	Interprofessional, collaboration, teamwork, communication, professional competence, interdependence, curriculum, education
15	Willems, A., Waxman, B., Bacon, A. K., Smith, J., Peller, J., & Kitto, S. 2013. Australia – Canada / Journal of Interprofessional Care, peer-reviewed	Interprofessional non-technical skills for surgeons in disaster response: A qualitative study of the Australian perspective	Qualitative, interviews, thematic content analysis	Teamwork, communication, non-technical skills, role adjustment, conflict resolution, education
16	Wilson, L., Callender, B., Hall, T. L., Jogerst, K., Torres, H., & Velji, A. 2014. USA / Journal of law, medicine and ethics, peer-reviewed	Identifying Global Health Competencies to Prepare 21 st Century Global Health Professionals: Report from the Global Health Competency Subcommittee of the Consortium of Universities for Global Health	Report	Global Health, education, competencies, curriculum

5.3 Data Collection Interviews

The first interview took place on 22.06.2017. The interviewed Stakeholder 1 (Sh.1) has extensive work experience in multinational teamwork in disaster and humanitarian aid and working in nursing job in hospitals in the Middle East. The second interview was conducted on 18.07.2017; the Stakeholder (Sh.2) work experience in multinational teamwork includes working outside of Finland in Norway and Middle East and over 10 medical missions in development countries. The third interview was conducted on 19.07.2017; this Stakeholder (Sh. 3) has besides a nursing degree, followed courses in disaster relief nursing and an emergency preparation course. Work experience of Sh.3 includes repatriation of patients from countries outside of Finland and since the last two years working in the Middle East.

The stakeholders were selected from previously known colleagues of the author. All Stakeholders are female, registered bachelor degree nurses. All are Finnish and over 45yrs. of age. Inclusion criteria were availability for a face-to-face interview between May 2017 – August 2017 and work experience in multinational teamwork.

The interviews were conducted individually, face-to-face, recorded and transcribed verbatim. The length of the interviews varied from one hour and 27 minutes to 51 minutes and 42 minutes. The stakeholders were provided an introduction letter in preparation of the interview (Appendix 3). Confidentiality and anonymity was assured. A semi-structured method of interviewing was applied.

6 ETHICAL CONSIDERATIONS

Ann Bowling writes in her book “Research Methods in Health: Investigating Health and Health Services” that all research has the potential to raise ethical issues and therefore even before a study starts consent should be obtained. She continues to mention several subjects of concern, such as research honesty and transparency, robustness of the research design, concerns how the research might negatively affect the participants (e.g. distress or embarrassment), time demands, privacy, confidentiality and anonymity, security, data protection, written consent. Important is the protection of trust on which the society and research community depends and the good reputation of research should not be damaged at any point (Bowling, 2014).

There are different levels of violation of good scientific practice, from ethical carelessness and misconduct to fraud. In the article from Resnik “From Baltimore to Bell Labs: Reflections on two decades of debate about scientific misconduct” and by the same author “What is ethics in research & why is it important” there is an in-depth evaluation of the various levels of violation of good behavior in scientific research. Examples of punishable misconduct (fraud) are fabrication and falsification of data and plagiarism (Resnik, 2003; Resnik, 2011). Acting against the ethical concepts and principles such as honesty, integrity, trust, accountability, respect, confidentiality and fairness, on purpose or otherwise is seen as violation of good scientific practice (Shamoo & Resnik, 2009). These ethical concepts and principles have to be evaluated in each and every step of the research work.

The Finnish advisory board on research (Tutkimuseettinen neuvotellukunta TENK) is an institution appointed by the Ministry of Education and Culture and is in cooperation with the Finnish Research community providing guidelines and handling misconduct cases in research in Finland (Finnish Advisory Board on Research Integrity, n.d.). Both Universities of Applied Science ARCADA and DIAK have committed to the rules and guidelines provided by this institute. The question “what is the subject of the research” goes hand in hand with the ethical consideration of how society and/or participants will

benefit from our research, in other words reciprocity has to be evaluated (Creswell, 2012).

M. Barret describes in the article “practical and ethical issues in planning research” that the research questions need to be explicit so that the topic of research is clear and can be answered and evaluated for ethical concerns (Barret, 2007). Areas of careful consideration are e.g. if the research question and consequently the data collection will cause harm to the participants or cause distress or embarrassment.

The literature search shall be conducted in a transparent way. In the literature review it has to be shown how the selection of literature was achieved (search words, search method) and bias should be avoided. Inclusion and exclusion criteria’s have to be revealed. Permission to use the selected material has to be assured and proper acknowledgement of authors is needed (Piccolo & Thomas. 2009: Resnik, 2011: Bowling, 2014).

The researcher needs permission /agreement to conduct the research before starting. When human participants are involved in the research there is a need for written informed consent of the participants. The participant has to be sure that the researcher will respect his human dignity, will do no harm, safeguard confidentiality and protection of the gathered data. The participant will be granted the right to withdraw from the research at any given moment if the participant so wishes (Piccolo & Thomas. 2009: Resnik: 2011: Bowling, 2014).

Also in the analysis of the data the researcher needs to comply with the ethical concepts and principles. Incorrect interpretation of the data should be avoided. If the analysis concerns secondary data, proper permission and references are obligatory. Plagiarism and falsification of data results are severe violations of good scientific practice (Resnik, 2003).

The planning process included what will happen with the results (disclosure). Results should be reported truthfully Miller, Christensen, Giacomini, & Robert, 2008).

Under the chapter discussion there are the interpretations of the research, opinions, possible implications and recommendations for the future or further research. Following the concepts and principles of good research practice as, this shall be done with honesty, avoid misinterpretation, cause no harm and give credit to other contributors.

In the article “Reliability and Validity in Research” there is quite well explained the meaning and difference between validation and reliability. The article begins with the sentence (quote) *‘THE HALLMARK OF science is the pursuit of truth and the limitation of error’* (end quote). This sentence holds a lot of the ethical concepts. One of the ethical considerations in research is that it should be beneficial to society. In the validation process it will be evaluated if what we did set out to measure is indeed measured in the process of the research. The evaluation of the reliability will tell if the results are a stable outcome (reliable outcome). Ethical concepts of rigor and trustworthiness are elementary parts of the validation and reliability process (Roberts, Priest & Traynor, 2006).

6.1 Limitations

The author conducted the data search for the literature review alone after receiving valuable advice and guidance of the information specialist of the education institute. The author worked diligently to adhere to the ethical principles of integrity, honesty and avoiding bias in the selection of articles. Inclusion and exclusion criteria’s were applied. Only after careful consideration articles were selected / excluded from this thesis, however it is possible that another author would find that articles excluded based on “repetitive of topic after saturation” criteria should have been included (Katapodi & Northouse, 2011).

Limitation in the literature search consisted of not finding explicit data or research on failures or dysfunctional multinational teamwork in the nursing sector. Also not having access to some full text articles and very recent articles was considered a limitation.

The selection of the Stakeholders and the number of interviewed was mainly decided by the volume of the thesis and availability of the Stakeholders. The number of interviewed

is very small and therefore the data provided cannot be valued other than personal opinions and observations that are not verified as general facts.

All interviewed are nurses from Finland, female aged > 45 yrs., all with more than 20 years of working experience, successfully performed / performing in multinational teams. The homogeneity of this group can be seen as a limitation.

7 LITERATURE REVIEW RESULTS

7.1 Multinational Teamwork

When teams consist of individuals of different countries, there is a mix of cultural backgrounds and ethical frameworks. Sometimes the differences in regards to values and beliefs concerning healthcare are substantial incompatible. These incompatibilities can lead to barriers to providing adequate care (10) (12) (15). Teamwork with Western and non-Western participants more likely create challenges on ethical issues, moral issues and professional practice (1)(10)(12). Elements described that influences the forming of an effective team were participants are “strangers” for each other are: trust building, professional competence, common understanding of teamwork, cultural differences, power differentials, common goals, cultural competence and language (1)(7)(12).

Interprofessional teamwork in literature is often named cross-cultural since two different work cultures meeting each other. Multinational teams and interprofessional teamwork do have overlapping challenges. Competences needed for interprofessional collaboration such as clinical skills, technical skills, communication, problem solving skills, professional competence, teaching skills, understanding and appreciation of other participants’ expertise and conflict resolving, are competences also needed in multinational teams. Attitudes of participants such as openness, patience, self-control, curiosity, tolerance, adaptability and empathy facilitate effective multicultural teamwork (6)(7)(14)(15).

More often than not, poor outcome of provided healthcare can be linked with non-effective teamwork. Failures in communication, teamwork and leadership are main contributors (7). Effective teamwork is a skill that needs to be developed, trained and maintained in healthcare work for all providers, starting already in their basic education (6)(7)(14). Cultural diversity has the potential to affect the quality of patient care and safety negatively (1)(2)(8). Cultural differences within the care team can lead to discrimination inequality, negative attitudes and disempowerment (2)(8).

7.2 Cultural Competence

The aim of cultural competence is described as (quote): “*Cultural competence aims to improve the quality of health care by reducing the cultural disparities that commonly arise when different cultures meet in health care context*” (end quote) (2). Or (quote) “*a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable them to work effectively in cross-cultural situations*” (end quote) (4)(8). Cultural competence is a lifelong learning process (2)(3)(4). Cultural knowledge contains learning about worldviews, languages, communication styles and other aspects that differ from one’s own (2)(3). In health care cultural knowledge would include knowledge about health related beliefs and values and treatment efficacy (2)(3). Cultural skill in health care is the ability to perform culturally based physical assessment (2)(3)(8). Cultural encounter represents the encounters with other cultural backgrounds. In this, participants should be aware of individual differences and not stereotype (2)(3). Cultural desire is an important element in the process of cultural competence. Cultural desire implicates the willingness to interact with other cultures (2)(4). Cultural awareness is the stage after cultural knowledge to be open to changing attitudes. Increased cultural awareness improves according to a substantial percentage of health care providers the quality of care (5)(8).

An essential part of cultural competence is awareness and understanding of the individual’s own viewpoints, beliefs prejudices and biases (see chapter 7.3) Some of the examples in the literature concerning cultural differences in health care given are: use of local herbal treatment, communication towards patients concerning serious diagnoses, death rituals, perceptions of pain, help-seeking behaviour (4)(8)(15). Lack of knowledge of cultural differences has led to providing inappropriate care and has been a source of offense (15).

The importance of cultural competence when working in a multi-cultural environment was acknowledged in all 16 articles, five of them refer to interprofessional/work cross-cultural situations (1-16).

7.3 Cultural Self-Awareness

In the reviewed literature the importance for cultural self-understanding/self-awareness is mentioned repeatedly. About cultural self-awareness (quote) *“An important step to developing cultural competency education has been described as developing self-understanding of what influences our own perceptions”... “The first step...is to understand...your own values and belief system and where it comes from and what it all means. You can’t really understand the other until you understand yourself”* (end quote) (15).

McPhatter’s cultural competence attainment model is described and we learn that the first step in the process to cultural competence is “enlightened consciousness”. The consciousness part is the mind-set, the belief system that affect’s one’s values and behavior. Enlightened is the phase where the shift from monocultural view to a multicultural view takes place. The outcome of this process leads to (quote) *“...a person to move beyond cultural superiority and creates a sense of equality between oneself and others.”* (end quote) (4).

Another term used in cultural self-awareness related literature is cultural imposition. When a person hold his/her own culture as the norm and can’t even imagine that there is another way or other points of views (different but equally valid views), this can be called cultural imposition. Cultural imposition expresses itself in imposing a person’s own cultural norms in their behavior or interactions within cross-cultural encounters (2).

7.4 Professional Identity / Competence

Multinational teams are very often present in disaster relief and medical missions. The activities expected to be performed by nurses can vary from what they are used to do. This can cause discomfort, insecurity and underperformance (9)(13). The ability to cope with these new challenges and tasks on the other hand is an important factor for nurses to continue with humanitarian work (7). The lack of evidence based training and education programs to facilitate optimal functioning in a multinational team is a barrier in forming cohesive teamwork in disaster relief (11).

In a multinational workforce where individuals each have their own values, beliefs and personalities and different educational backgrounds, placed in an unfamiliar and cultural different situation, can feel uncertain of what practices are acceptable in their care delivery. This can result in inhibition and create a feeling that the care is not clinically safe (2). The judgement of clinically non-safe practice can also be the result of cultural imposition (2). On the other hand finding the balance between respecting other cultures (norms, ethical values etc.) and not compromising own values can be challenging (10).

Disempowerment (deprivation of power, authority, or influence: making powerless, ineffectual, or unimportant) is mentioned in connection with professional identity and competence. Insecurity, differences of professional competence, cultural incompetence to name a few contributors, can give way to or create feelings of discrimination, inequality and negative attitudes. Disempowerment is a negative factor in providing efficient teamwork and promotion of a safe health care environment (2).

Awareness of national differences in legal aspects of nurse professional actions is important in understanding the competence, performance and ethical framework of a nurse in a multinational team. Openness, tolerance, collaboration in task division are helpful tools in building an effective team from individuals from different backgrounds and optimize the use of their professional skill and allow personal growth (10)(12). Individuals may be facing ethical dilemmas when their professional identity is challenged: facing a situation where they are expected to perform duties that they aren't trained for and possibly legally not allowed to in their home environment, can be a very distressing experience (10).

7.5 Communication

The theme of language in the articles chosen for this literature review on multinational teamwork is abundantly mentioned, most often in the same sentence as cultural differences. Misunderstandings in communication and lack of effective communication can result in confusion and conflict (8)(14). Skilful negotiation is a tool to overcome differences in viewpoints and resolve conflict in cross-cultural encounters (14).

The first thought that comes to mind concerning multinational teamwork communication is language. Most often English language is the common language in a multinational team, with individual differences in proficiency of English language. When the linguistic background of the team members present a great variety, it should be observed that for many English is the second language and may complicate communications and misunderstandings may arise. Language difficulties have a potential of negatively influencing nurses ability to practice competently and safe (2). Language barriers are stress provoking in multinational teamwork (10).

Communication is more than the use of a common language. Intonation, word choice, and gestures, are also part of communication. In some cultures it is important before discussion essential health issues to develop relationships first by talking about seemingly irrelevant topics. The physical distance and touching during a conversation can have influence on the effectiveness of the discussion. The use of gestures when linguistic barriers are present should be done with caution; some gestures that are acceptable in one culture can be very offensive in others (2). Cultural knowledge is imperative for effective communication (8). Understanding of other health professionals' roles and competences in the team promotes effective communication (14).

Openness, seen as an essential contributor to effective communication, can be hindered by perceptions of differences in status of the team members. A permissive environment encourages team members to freely express their thoughts and present ideas and solutions, which are beneficial for the final result of the team's provided service. Effective communication improves the quality of health care and vice versa ineffective communication is often the root cause of failure in health care (15).

7.6 Respect

Respecting other cultures and traditions and refraining from cultural imposition is indicated as important to many healthcare workers in multinational teams. However ethical issues may arise when other cultural values conflict with own moral convictions. Tensions may arise when these issues are involving e.g. injustice concerning views on humanity that were contradicting universal values (10).

Distrust is an obstacle to effective teamwork and providing adequate health care. Cultural bias can be a factor that stands in the way of achieving a cohesive team in multicultural setting. Effective communication and willingness combined with cultural competence can move persons from distrust to trust and respect (10)(14).

Acknowledgement and respect for the expertise of team members enhances effective teamwork and improves the provided health care (14). Lack of social respect between health professionals of different nationalities can result in feelings of intimidation and unfairness, leading to disempowerment (2).

7.7 Education / Training

The need for education is brought forward in all the articles that were chosen for this review (1-16). Variation is found in what this education or trainings should provide and in what form the education should take place. According to reviewed literature:

- (quote) “...*there is a need for a well-structured continuing education programme for nurses that aim to increase their cultural competence to enable them to provide high quality and clinically safe care. Specifically, education is the tool to enhance the sense of empowerment for the multicultural nursing workforce. In addition, such an educational programme should utilize and employ the best adult learning methods to ensure participation comprehension and understanding*” (end quote) (1).

- The use of cultural competence models in education is recommended (2). Cultural competence learning is a continuing, never ending process (4). The integration of cultural competence education in baccalaureate nursing programs needs the commitment of training institutes. Administrative support is imperative to achieve an environment that is supportive of diversity; commitment to cultural competence is fostered by a clear mandate. The cultural education programs should be evaluated on process and outcomes (3).

- Language studies of a not-so-common language if working in collaboration with a professional representing such a language group is possibly not beneficial enough if the time working in that environment is short (5). Interprofessional teamwork skills should be included in the curricula for medical education in a more consistent and extensive way to enhance professional development (6). Learning how to be effective team member is a skill nurses need to learn already early in their basic education. Team orientated culture should be promoted by managers (7).
- Gaining of cultural knowledge should be a skill that nurses need to develop. One way could be by reviewing published literature and attending seminars (8).
- Evidence based and standardized training and education and developing standards and guidelines for training in disaster training is highly desirable (9). Disaster response is more often than not a cross-cultural environment. Skills needed in disaster relief often present nurses with new professional challenges. More research in what these skills are would facilitate in creating an effective training program for nurses preparing for global health competence, humanitarian aid and disaster relief and fortify professional competence (11)(12)(13)(16).
- Prior to commencing work in a multi-cultural environment, cross-cultural living experience should be considered as well as language learning and introduction to the culture of the environment. Preparation for dealing with complex ethical issues should be included in training (10).
- (quote) “ *Nursing education needs to include cultural sensitivity and safety, related to cultural differences at national and local levels, including global health issues and preparation for greater cultural diversity would benefit nurses at all levels and in all areas of practice* ” (end quote) (12).
- Education efforts, with the aim of positive patient and providers’ outcome, should focus on improving health providers’ communication skills and role understanding (14).

- Conflict management skills (in disaster environment) would be a beneficial skill for healthcare providers (15).

7.8 Summary of Literature Review Results

The importance of cultural competence as well as need for training in teamwork is highlighted in most of the articles chosen for this literature review. The elements of cultural self-awareness, professional identity/competence, communication skills and respect are important factors which cannot be ignored in achieving cultural competence and effective teamwork and thus resulting in safe and highest possible standard of patient care.

Communication in multinational teamwork is a much wider concept than language skills only. Effective communication requires all the above mentioned elements. Compliance with evidence based practice facilitates communication and cohesive teamwork. Conflict management is described as useful to be part of trained communication skills.

Other elements mentioned in the reviewed literature as influencing the functioning of a multinational team are: cultural desire, cultural bias, trust, cultural superiority, cultural imposition, disempowerment, education, ethical dilemmas and professional performance.

8 INTERVIEW RESULTS

It was surprisingly easy to obtain the cooperation of the stakeholders. All replied when asked for the interview immediately that they were very keen to tell their side of this topic as they found it relevant and needing attention from nurses, educators and employers. With the knowledge that the conversations were confidential and the trust in the author that sensitive data would be handled with great care and consideration for research principles as e.g. do no harm, the Stakeholders shared their opinion with the author.

8.1 Multinational Teamwork

The element that surfaced in all three interviews as important for successful international teamwork was standardisation and (written) protocols for procedures. As Stakeholder 1 (Sh.1) said:

“Standardization is crucial. In American hospitals everything is standardized, so it is easy to work there. And procedures should be written down in English as well as local language. There has to be an agreement whose standards and policies will be followed. If it is written down then it is easy to refer to, especially if there is a disagreement.”

“Of course, unless you have like in (name of organisation Sh.1 works with) the principles which are common and you can always refer to that if something happens which is like a conflict, so you can refer to that, but in a normal situation, you have to have something to refer to, like agreed agreements, policies, hospital policies, or ward policies, or something written to refer to what is kind of neutral. But you should never rely on yourself in that sense, you should have something to refer to if there is a conflict or argument, professional conflict how to do, what to do. So that you are not alone, you rely on either some written policy book or procedure books.”

The same observation was made by Stakeholder 2 (Sh. 2):

“Following guidelines and to know them is very important... Protocols can help to prevent professional conflict.”

Stakeholder 3 (Sh. 3) formulated this as followed:

“It (international teamwork) is working maybe because we have these policies. So we all need to do it in the same way. So we provide the same level of nursing, basically.”

When there are no policies, or when existing policies seem not providing the best possible care in the opinion of a team member, the way to open the discussion is presenting reliable “evidence” (Evidence Based Practice); research papers if available or by showing in practice and evaluating as Sh. 2 presented from her time working in the Middle East:

“Main difference was how the fellow colleagues, related to me. In one place...I think...in the end they were scared of me or my skills, afraid to be overshadowed maybe. There were things that I knew very well and tried to explain to one nurse. And I went to another nurse and told that I know that this is the way to do it, I have been doing this for 20 years back home. Well, she told me, you have to find something written and show her the text and she will do it as you tell her.”

The need to present evidence and evaluate in the team, listening to each other, can be found in what Sh. 1 said:

“You have to be sure about your own skills and you know what to do, secure in a professional way. And then you should also have, never forget that also other people have also the same. They also are trained and they know, and you have to find a way together.”

Sh. 1 continued on this topic:

“..you did a quality measure. And how you performed and then...every now and then there was randomly picked team quality measures how the case was done. And then there was this constantly weekly workshops. Among the team, you know tackle some policy and procedure. And presentation, everyone was taking turns in presentations for a small group of colleagues

The functioning of the team members is not only depending on the execution of protocols and guidelines, according to the interviewed. The interaction between the team members is an important element as well. Many factors play a role in how cohesive the

team is. Items that came up in the interviews; is there a dominant language/culture group within the team, are team members treated equally by their superiors, is the work environment culture more familiar for some team members:

“And of course, because we were westerners, so we were adapting to the American very well, thinking of for instance some (nationals) or.... Somehow their thinking and culture and religion of course was same, so it...without mentioning it gave some connection easily than for instance let’s say nurses from eh (nationals). Of course for example (nationals) nurses were more at home in Saudi as a cultural Islamic country. But as a team we were not, we were only medical, but still without speaking the connection with westerners was stronger somehow. But there was no conflict. We never had any cultural conflict in that way.” (Sh. 1 on working in Middle East)

“I don’t know what it was. I felt excluded by the nurses and doctors and thenI have bad hearing, I didn’t always hear what they were saying. I was a bit on the outside there. They (nurses from certain geographical area) were very mean to me, they complained about me. When I forgot something they were shouting at me. It was a kind of psychological thing, I felt bullied. It was an unpleasant work environment for me. Yes I think so, maybe cultural friction.” (Sh. 2 on working in Middle East)

“Sometimes they (name of geographical area) have done that, they tried to get rid of the nurses that they don’t like and the Westerners are the most they don’t like. But nobody can do anything about this. I have nice house and garden, they don’t have the same. But this is not my choice, this is done by the employer, it is not my fault. And this creates tension; it is not good for the team.” (Sh. 3 on working in Middle East)

“...nationality probably, or the training or something.... it matters... a lot. Unless, perhaps in some places even if they don’t admit it, to be a Westerner... you are listened” (Sh. 1 on working in Africa)

The nature of the work (e.g. disaster relief work, medical mission or normal hospital work) influences the demands on the team members’ interactions:

“You are concentrating on what needs to be done, you are not seeking consensus on everything, or you have no meeting every morning on how we do this and that, because

it is too much work and everyone is concentrating on their part of work.” (Sh. 1 on working in disaster relief)

Personality traits of the team members and cultural background play a role in the behaviour of the team members:

“(Certain geographical area) type you know, they were never expressing their opinion if it was different from their head master. So they were kind of easy probable for the leader of the unit in that sense.”

“When people go out, I remember there was the Swedish group sitting in their table and then the Americans in their table. That’s how it happens. But if it is only one or two Swedish nurses, then we are all together.”

“Also that you are loyal to the team, so that ...let’s say this loyalty for instance this drinking and things like that, to a certain point you are loyal to the team, you don’t spread things around about your team. It’s not just like a hush-hush, but it is just kind of it might destroy the good work. You can always comment afterwards, when the situation is over, but not in the situation.”

Stakeholders mentioned elements that promote teamwork:

“Flexibility, not to mind about small things. Sometimes people complain about pollution or sick children and so on and don’t want to come back again with (name of organisation). But I see that the locals are so hard working and waiting for us to come and it is such a big deal for them, so I want to go there again. Flexibility to see the big picture, not think about small issues. If we don’t go there things are even worse for these people.”

“Americans were generally very good humoured and supportive and encouraging and never criticizing in a bad way. If there was a meeting or so, they were supporting.”

“...and also, be friendly. We all ...you can be tired on those missions and you can be down, but then you have to explain and say sorry, this happened, talk with each other! Be open.”

“You must be hard working, hardworking not lazy. Not lazy. You must have initiative, no one can have time to drag you or ask you. Initiative. You have to be trustworthy, that if you have agreed that you do this and I do that, so then everyone is doing what is agreed. And....also not complaining.”

8.2 Cultural Competence

None of the interviewed Stakeholders had received teaching or training on Cultural Competence during their basic nursing training. They all received some kind of cultural related information prior to commencing their assignments. Their comments:

“One week some kind of preparation for the new nurses, where they tell about cultural differences and what it is like to work in Saudi, but they never told us things like this that we only one going alone...we only found out when we arrived. We learned about Arab/Muslim culture, but not about working with nurses from other cultures. They did tell us that there are nurses from twenty something other countries in this hospital and that they have different ways to work. That you have to learn to work together, that’s why they have really strict rules, that there is only one way to do things, and that is only this way. Because they all came from different countries, they had different way to work, so you had to do it only this way and there was one nurse that went through the rules and checking that and writing down if you were doing things correctly. I think it was good. I learned a lot to develop my professional performance. It is really good to have strict rules. In Finland they are going more and more in that way, that you can’t really work to do just as you like.”

“Then I realized this all over sudden, this is really interesting (working in multi-national environment), this is really good. This... I like to work here.”

“This is very good to see that everyone is on the same level. Even though it is very hard in the first three months, because it is a different culture, you have to know of course, about the Muslim something and prayer times and all the cultural things and then you

have different kind of nationalities and they have the different kind of ways of doing things. It's quite a soup! It's difficult."

"And I did not get so much information before from the agency to prepare about culture things in the hospital. That is a challenge. And how it is to be a woman in this culture, how they will treat you, so if you know then it is not such a big deal. But at our hospital it is quite okay as a woman. But the thing is like they have...if you get the patient for instance from the O.R of course you want to see everything, you want to check the temperature of the skin and then you have to think, ohh this is a male and some male don't want you to touch because you are a not a Muslim and a woman."

Cultural competence is not a subject that concise of cultural knowledge only, but it includes cultural desire. Sometimes this part, cultural desire, becomes a major obstacle in working in a multi-cultural environment. Sh. 1:

"Of course it was good to know, basics. For instance I didn't know anything about Islam before that course in Copenhagen, dress codes, behaviour codes, practical things, of course that helped. But not everybody still was accepting this easy, I know many people who just left before their contract was done, because they couldn't take it. They left with slamming doors. You know somehow.....They accepted it on paper in the course, but in practice they didn't."

8.3 Cultural Self-Awareness

Cultural self-awareness is part of achieving Cultural Competence; know oneself to understand the other. Part of the "know oneself" is to have knowledge and understanding of the values of the organisation one represents. The performance of the team(members) is influenced by the mandate they have received from the beneficiaries, e.g. is the team working autonomously or in an advisory capacity:

"... in the role of let's say field hospital you are in charge, so you have, you are in charge of the level of the work. So then you have the right to, even professionally say that procedures they are done this way, because in our hospital it is done in this way. Or if you, let's say, it is a bit difficult sometimes, like let's say in (country) it was only two of us, surgeon and me. We were going around, kind of helping and teaching and

little bit of also quality promoting the better quality. But clearly we are visitor. It was not our hospital, we were not long time, we were few weeks or something. The purpose or goals was, so then you have to really make clear that my position, I am here to help you, but help you in the way that it is easier for you to work in the future. So not helping just to do this case, but that you after this case you have some other ideas perhaps how to do the thing. So you have to be very diplomatic, but also you have to be aware of that you are not here just to you know that if some (nationality) nurse who is not actually really not at all trained but learned by doing, is telling you that you do it this way. So then you are not doing it that way but then you say no, I am here that we are doing it together and let me show you how I do this. So this is quite difficult, it is easier in let's say in a (Organisation) hospital.”

“But if you are visiting and you are working in an international team, you know little team with (nationality A), or perhaps one (nationality A) nurse and one (nationality B) nurse and you. And the (nationality B) has never said anything because they are also visitor and they just do what (nationality A) are telling. And (nationality A) know nothing. So then it is a hopeless situation. But if I go there, I am not doing what they are telling, even if I am visitor also, but my organization has other expectations on me. And I can tell them, I am not here because of my own, I am here for the invitation of your hospital and I am from (Organisation) and I am here just to do with you so that you can see also other kind of ideas perhaps. So, it's little depending on the situation how you perform. Or how you, are you free to perform your own standards or are you, do you have to make lot of compromise, but there is a limit were your compromises are. Not endless.”

Inner conflict may arise when core values differ. Compromises between what is learned and practiced “at home” and in the guest environment are sometimes inevitable:

“I don't know, they don't really have anything, they just try to cope. We have the disposables things and they just take all these and clean them and re-use them. First I thought it is terrible, I am not going to be in this, but that's the only way they can cope. They don't have the instruments, they do.... They don't have the sutures.”

The way of interacting between the different professional disciplines can vary from culture to culture and will benefit from self-reflection in order to adjust to the presented situation. Sh. 2 commented:

“...it depends on the person. Usually the Western nurses and surgeons, they are even. The culture is so different in for example (country A) or (country B). I remember the (country A), one surgeon...But I think it is more about personality. And then it is only a few weeks, so you try your best and try to find solutions to make it work, like with the (country A) doctor to let him work with a (country A) nurse. Because sometimes it is the culture that they understand, but it is sometimes culture. You adapt, you can't change in few weeks.”

The motivation of becoming a nurse and linked to that the status in society can be influenced by the culture of the country of origin. When working in a team with members that have a different regard of the nursing profession, it can create inner conflict:

“It is not pleasant to work in this way. It is, like...is it thankful? Like, I don't feel after my working days that I have done something good for the patient. I only have followed what's the orders. For most of the day I want to leave, because there is a concern about the patients, because the fact is that they don't get good nursing. So that's the things why nurses struggle. Most nurses struggle with this. Not all. Western nurses choose to be a nurse from the heart or it is anyway the own choice. But for many (geographical area) the choice is made by the parents, because they know that there are jobs and after graduation they can go abroad and send the money home. So if you do this job only for the money, it is different how you feel and how you treat the patients.”

“And if you have to work in a situation where you employer...the rules of the country, that culture is so different from your own that it gives you conflict inside, it is hard to work in that situation. And if others in the team can work and don't mind you feel alone and frustrated and don't want to be there. And you cannot function in the team.”

8.4 Professional Identity / Competence

The nurses that were interviewed for this thesis all had extensive work experience in their nursing profession (in their home country Finland) prior to joining multi-national teams. Cultural competence, Cultural self-awareness and Professional identity / competence are closely linked concepts in multi-national teamwork. The different education systems as for example seen in post-graduate courses and diplomas or the lack thereof and different levels of professional independency become a challenge for employers and employees in multi-national teamwork:

“We have this...you have to do the PALS (Pediatric Advanced Life Support) and ALS (Advanced Life Support) and competence, about 100 different competences, like taking blood samples and so on. You have to renew every year most of them, not all. And you have to get different kind of points; you have to pass certificates, certain different kind of study things, to study in your own time. And blood work things and basic life support things is yearly and also lots of different kinds of policies. So its most of the time, all the time there is something education and some practical things that you have to show that you know. It is actually good; it suits for there, because in our hospital I heard it, there is about from 50 different countries. In our PACU (Post Anaesthesia Care Unit) where I work, we have from 11 different countries. So we have 11 different kind of education background. So of course they want to be, in that hospital they have the policy how we...how they wanted this kind of patient to be nursed.”

They didn't force me to check, but they were more dependent on what the doctor says and... "he didn't tell me to do this", for instance. But I said there is no need to tell, because automatically I do it. Or asking me "why are you doing it, did he ask you to do it?", I say, no, but this is my job.”

The individual perception of professional performance in a multi-national environment varies depending on the individual personalities, environment, assigned task and expectations of Stakeholders / employers. One interviewed expressed her opinion as such:

“I had to change my attitude a lot in my work. Our work in Finland is so much different from the work in Saudi. Of course nowadays we have to have the orders so of what painkillers I can give and I can choose, but in Saudi I can't give anything without or-

ders, even not oxygen I can't give. And this so limits your nursing, you have to know one thousand million things in this competence test and ALS and so on, but basically you are not allowed to do anything without the doctor's prescription. And it has to be written in the computer and if you get the order by telephone, two nurses have to hear the same order. And so this is really slowly and complicated things. And I was used to make own decisions, because I have 18 years of experience as a nurse and I know what might be the best thing to do and blah, blah, blah, but here you should do only do what you are told to do and not use your own brains."

"It depends what the nationality the doctor is from, if the nurses and the doctors are together a team or not. If they are Westerners we work the western way together, and they trust about that I am right and they might follow what I think might be the best for the patient, because I am the one who is besides the patient bed all the time, so I know. Doctors from other countries are not used to that and nurses are more like their slave, and they do what they ask them to do. But you cannot generalize that all doctors from certain countries are arrogant."

Working in multi-national teams, offers the opportunity to compare and learn from each other, modify skills to new surroundings and achieve professional growth:

"We were supposed to teach them, but the nurses in my room they were really experienced, so it was easy" (Sh. 2 on working in Asia)

"Professional challenge and reward what makes it feel right. And chances you will not get at home." (Sh. 1 on working in disaster relief in Africa and Asia)

"..the hospital was really poor. But (organisation) brings all the instruments and everything, so that's really not that bad and (organisation) had been there very many times, so the local surgeons were really good. And I have to think about the local nurses. I think they were really experienced too, they were good nurses there, hard working. Yes it's true. So it was a positive experience..." (Sh. 2 on working in Middle and South America)

“When somebody was talking about that we should really promote this quality assurance you know, and I was really lifting my head immediately. Yes, yes, yes, that I have been working and kind of promoting that, in that sense I try to...I try to promote these things that I have learned and seen.” (Sh.1 on returning to work in Finland)

“You have to do anyhow do compromises because of the circumstances. So but in that sense that you even under these circumstances you know the safe way.” (Sh. 2 on working in Africa)

8.5 Communication

Language skills are a major element in communication in multinational teamwork. The level of fluency in the assigned language is having an effect on the professional performance of the team, but also on the wellbeing of the team members:

“The first time I didn’t speak English that well. I thought that I spoke well, because all the test that I did went well. I read very well, but I couldn’t speak it well.”

“I have been many times in groups were I didn’t speak the language, but I didn’t feel excluded. There are different ways to make one feel part of the group. But this (country) group made us feel like we were air; they didn’t even look at us.”

“The young nurse asked something about learning language. The older nurse said that it is not so important. Then I could not help but said now I have different opinion. You have to know English, because you are not alone, you are in international team and you are supposed to teach and train and you have to learn it.”

“The language barrier that is always the feedback I give, the language barrier is always the problem, because we couldn’t teach as much as we wanted to and we didn’t understand each other. I think that is the main thing.”

“And it was difficult to bond with the local nurses because they spoke only French, and we had only few translators and they didn’t know how to work. They just stood there

and we couldn't explain what to do. And they didn't know anything about the aseptics. That was a frustration because of the language barrier."

"Sometimes there are days that I use my English only with the doctors and some with the patients, but not so much with the nurses. That makes me feel like an outsider. Because I don't know what they say about the patients from the O.R in the reporting, even if it is not my patient, I should know something about the patient, what they have done inside. The handover is done in their own language. I will need to take all the blankets and see where is the wound, because I don't what they say. If there is too many nurses who are from the same country...they might forget that English is the only language that we can use in the hospital at work."

"Finnish people are at a disadvantage because of the structure of their Finnish language and behaviour (ha, ha). I have tried to soften Finnish behaviour and language, because I was very ashamed of some behaviour, but now I realize it is not my business."

Besides the language skill the way of communication may vary from culture to culture. Being sensitive towards these differences and adapting to the other culture will influence the team performance. When working in a leadership /teaching role, understanding the non-verbal communication in the work environment is maybe even more important. Giving feedback or changing existing work models requires consideration of the appropriate form of communication:

"...and there are also the nationalities which are very sensitive about, you know, the face, to keep the face. You should never make them loose the face, because then you will be lost, your work is not done, nothing if they start thinking that you are embarrassing people in front of other. Like when you were dealing with these kind of cultures where losing the face is the biggest insult and causes immediate breakdown of the whole thing."

"I try to do it in different way, even if they said we have always done it like this. I will say but we can do it also like this, without even saying that it is better, but saying that we do and they can do it. It is not that you demand something that you don't have in that place. But even with the resources or things you have you can do it in a different

way. Still, so I will introduce that different way, and discuss it. We have had some quite heated discussion because some people they are very, let's say (nationality A and B), are very, very self-conscious and ...ooei even more than Finnish: "We do things like this!" And I say that let's see, let's try, let's try this way and I am not controlling that you have to do it, but let's try this way and I do it, and we do it for instance with my colleague and together we can assist each other and do it the other way."

"But I would not approach in that way, certainly not. Let them do what they do, I do my way. And slowly in a team they will realize that your way is better. And they will adapt it. I am not telling it, or will tell that I am use to do like this, let me do like I am used to and they will realize that this is good."

"I will never directly criticize if they do their own thing. But if I am involved, together, if it is also my business to do this, so I will tell that try to this and I try to do this. But I will not go to other places and say to someone, hey, hey hey, what are you doing!"

8.6 Respect

Respect in multinational teamwork was mentioned in the interviews as important towards success of the team performance:

"But if that person in my eyes has a high professional, I respect professionally. I will swallow a lot. And I say nothing, but try to do my best. So it's a little bit depending on this. Of course respect can be as a private person also. But in this thing, the professional respect is important. If people respect you professionally, so then they swallow a lot from you. You don't need to be nice and social and bring sweets."

"Two, no, three Bedouins became my students, who had never seen foreigner who... they really said that we will not listen to foreign Christian lady telling us, but after few tears and many evenings thinking that this is not going anywhere, after couple weeks I realized this also what I want to do. And we got along very well. And I was proud to be present at their graduation ceremonies."

“No one has ever told me this, but I could see that some of the local nurses are so experienced that I can see that they know everything, I don’t need to teach them anything and they work according to the guidelines. So I let them just work and I tell them okay now you can teach me how you do things here.”

“And the cultural differences in different countries, you have to learn them. But I think ...they try to teach...the coordinators send us something about the culture of the country, how they...don’t do this and do this. And this is how they cope in this country. Respect for the culture is important.”

When differences in core values like Human Rights between team members and work environment exist, inner conflict may arise:

“...and respect other cultures and religions. We are in another country so I should follow how they are and respect what they believe, and respect like their prayer times, even though some things are irritating me. But human rights things are a difficult thing, but you know that can’t do anything, so you have to accept them or leave...go back home if you can’t face this. It is hard to see how they treat people differently.”

8.7 Education / Training

The Stakeholders commented on education and training concerning working in a multinational/multicultural environment as followed:

“Business people are trained on behaviour, but not healthcare personnel. Organizations don’t spend money for that training. They think that if you can work at home, so you can work in the field, no one pays much attention to your behaviour. But it would be good to get that kind of training for medical personnel. I hope that the younger generation is better, different. Maybe their English skills are more natural. And they have been more exposed to overseas experiences. On the other hand the practical skills nowadays are less all-round, so there might be more professional insecurity.”

“I, perhaps I have generally read in some book or some program or something about, little bit about different countries or cultures or this, but not specifically. But of course you gather, without realizing, you gather some information when you read books or

look at the...read the stories of different places. But no, I have not had any kind of training specifically in that question.”

“Of course you know the general, tolerance like this, that you understand that people are different and they think differently, but they still can work according to the guidelines...But I think it is very much a question of personality. How much training, how much thinking, reading, blah-blah-blah, not everyone likes it (multinational work environment). So, and you cannot force your people who doesn't fit, who is always grumpy and complaining this and that. People who are like that, so it is better that they find a work, a team where they like to be. People are different.”

“Education and standardisation. Exactly, exactly, definitely, it is critical. It's critical, otherwise it would be...let's say in Saudi at that time, you know we were one nurse from Tunisia and one nurse from Finland and one nurse from America would never fit in to do their thing without this standardization.”

“And teamwork! And communicate in a nice way, and respect and you know..”

“It depends a lot on the attitude I think, that's the main thing, your attitude. And you are here to work, and when you go there you are there to work and help and that's the main thing. Everyone is willing to work together and learn from each other...they pointed out that each and every one of us is really important for the team. They(organisation) stress that the team work is the thing, we do it as a team.”

Education of nurses, learning teamwork, yes it is really important. I remember in the beginning I have to teach them, that this is a team... So they have to learn those skills to, they don't necessarily know how to do it when they start. This was in (country). But when you teach them they are actually, they are really happy and they are doing it and they are responsible, some of the nurses, it is again about personalities. But they are not used to work as a team, no.”

“Of course, personality is a big factor, some people, a lot here, cannot work in a team. But, yes, you should be open and accept that you don't know everything and you should

be open to new things and learn new things. Not too stubborn. We have teambuilding days, twice a year. Maybe it helps, because it is outside the hospital and you get to know better your colleagues.”

8.8 Summary of Interview Results

Key elements for effective multinational teamwork emphasized by the stakeholders were; standardisation and protocols, cohesive teamwork, equality and acceptance between team members, communication skills, evidence based practice, respect and education.

Ethical dilemmas and compromises on professional level were presented as core issues for inner conflict and frustration. Personality traits mentioned in the interviews were; loyalty, flexibility, support, encouraging, friendliness, initiative, trustworthy, diplomatic skills, patience, tolerance, openness.

Terms like cultural competence and cultural awareness were not used by the Stakeholders. The need for education on cultural and cultural differences was identified. The subjects of cultural conflict and cultural willingness although not named with these exact words, were repeatedly mentioned in the interviews.

9 LITERATURE REVIEW AND INTERVIEW FINDINGS COMBINED

To categorize the data from the literature review was a logic process that was enabled by identifying main elements and their components. To categorize the data from the interviews in the same way was not so straight forward, but felt needed by the author in order to compare and combine the results of the both.

Overall the findings of literature review and the interviews corroborate each other. However the interviews provided by means of observed word choice (strong explicit words and repetition) intonation and body language, indications of the elements that stood out in the stakeholders experiences in multinational teamwork. Describing situations causing inner conflict based on differences in ethical perceptions and values provoked strong emotions in the stakeholders. In the literature these issues are mentioned, but it's the author's impression that these issues in the literature don't reflex the seriousness and impact as strongly as emerged from the interviews.

A difference between literature and interviews is the use of terminology like cultural competence, cultural self-awareness, evidence based practice (EBP) and professional identity/competence. The stakeholders didn't use these terms and were (partly) not familiar with these words, but describe situations where these terms could be applied.

In the data from the literature review as well as in the interviews, the teamwork enabling personality traits of team members are presented and the similarities are found. The traits that stood out in the interviews, more than presented in the literature, were friendliness and (not) complaining.

All stakeholders felt very strong about the need for standardisation and agreement on procedures and policies in multinational work environment. The importance of standardisation was less stressed in the literature.

Table 7. Keyword/concept comparison literature review and stakeholder interviews

	Keywords in literature review	Keywords in Stakeholder interviews
Multinational team-work	Professional competence, common understanding of team work cultural differences, power differentials, common goals, cultural competence, language, openness, patience, self-control, curiosity, tolerance, adaptability, empathy, discrimination, inequality, negative attitudes, disempowerment, standard of care	Standardisation, protocols, policies, conflict solving, professional conflict, level of nursing, written text/ research (<i>EBP</i>), quality measure, presentations, culture, equality, cultural friction, conflict, loyalty, flexibility, support, encouraging, friendliness, initiative, hardworking, trustworthy
Cultural competence	Working effectively in cross-cultural situation, communication styles, culturally based physical assessment, cultural knowledge, cultural skill, not, stereotyping, cultural desire, cultural awareness, quality of care, prejudices, biases, cultural differences, interprofessional,	Cultural differences, work together, cultural nursing, cultural knowledge, woman, behaviour, cultural desire
Cultural self-awareness	Self-understanding, perceptions, enlightened consciousness, cultural superiority, equality, cultural imposition,	Mandate, quality improvement, cultural superiority, diplomatic, compromises, inner conflict, adapting, frustration
Professional identity / competence	Discomfort, insecurity, underperformance, evidence based training, cohesive teamwork, educational background, values, beliefs, personality, respect, compromise, disempowerment, different professional competence, cultural incompetence, safe health care, ethical framework, openness, tolerance, collaboration, ethical dilemmas	Post graduate courses, certificates, educational background, independency, professional limitations, teaching, experience, , quality assurance, compromises, safety
Communication	Language, cultural differences, English, second language, barriers, stress provoking, intonation, word choice, gestures, physical distance, cultural knowledge, effective communication, confusion, conflict, skilful negotiation, openness, status, permissive environment, quality of healthcare	Language skills, exclusion, barriers, frustration, dominant language group, embarrassment, diplomatic, patience, criticize, non-verbal communications
Respect	Ethical issues, cultural imposition, cultural values, conflict, moral convictions, injustice, humanity, trust, acknowledgement, intimidation, unfairness	Professional respect, professional skills, cultural respect, respect for religion, human rights, acceptance
Education / training	Increase cultural competence, quality care, safe care, empowerment, administrative support, diversity, evaluation, professional development, team orientated culture, evidence based, standardized, research, ethical issues, preparation, cultural diversity, role understanding, conflict management skills	Behaviour, practical skills, professional insecurity, information, tolerance, guidelines, personality, standardisation, attitude, teamwork, willingness, teambuilding

10 DISCUSSION AND CONCLUSIONS

10.1 Discussion

The author is reminding the reader that the sample size is small and therefore caution is needed when drawing conclusions. The author is not claiming to have uncovered facts that provide explicit answers for the research questions, but rather indicates areas in need of further empirical research to verify the value of the authors' findings.

As established when commencing the literature data search, articles that dealt directly with multi-national teamwork of nurses and its successes or failures are hard to locate, neither data on the consequences of dysfunctional teamwork was found. The question arises if it does exist? What could be found were elements that emerged as valuable to good teamwork and multinational/multidisciplinary. To find research material and articles on multinational teamwork from other environments like aviation, aeronautics, defence forces and business-world was on the other hand not difficult at all. The challenges of multinational teamwork have been researched in sectors like aviation, aeronautics, defence forces and business world. The implications of failing teamwork in these sectors are found to cause, among others, loss of lives and financial losses. Developing and implementation of strategies to mitigate the negative impact of failing multinational teamwork in these sectors is an ongoing process which they take very serious.

After the literature data collection the next step was three interviews with bachelor degree nurses from Finland (stakeholders). All three nurses possessed extensive experience in working in a multicultural environment. The main selection criteria for the interviews was availability and as it turned out all nurses were female and >45 yrs. of age. The stakeholders were provided with an introduction letter and thus were aware of the aim, purpose and research question of the thesis prior to the interview. During the interview the author minimized her participation to mainly listening and follow-up questions. The author intended to get indications of what were the most important elements in multinational teamwork for nurses according to the experiences of these experts and find out if there were confirmations, discrepancies or gaps between the literature data and interview data.

The possible reason why there is limited material available concerning the failures in multinational teamwork for nurses was discussed with the stakeholders. One stakeholder suggested that loyalty to the team or fear for repercussions from the employer are reasons that failures are not discussed nor recorded. This stakeholder contemplated that maybe internally in organisations there could be some data, but probably they (organisations/employers) “don’t dig too deep”, they just employ another nurse and certainly don’t want “to hang their dirty laundry out to dry for everyone to see”. Empirical studies on failures and disappointments in multinational teamwork with facts and figures on causes and effects would give valuable information on what is and isn’t working in multinational teamwork and thus provide indications of what needs to be done to improve multinational teamwork and why.

As described e.g. the aviation sector has done a lot to address the challenges of multinational teamwork for the obvious reasons that failing teamwork “in the air” has led to major incidents with many lives lost. The same (concerning efforts made) can be said of the business sector, their reasons most likely being financial gain or loss driven. Would it be fair to say that if other sectors have identified the negative outcome of failing multinational teamwork, that it is very likely that also in medical multinational teamwork there are negative consequences?

None of the stakeholders received any cultural competence education in their nursing career. This could be explained by the fact that they graduated in a time that the nursing education was focussing on technical nursing skills and knowledge on subjects like anatomy, physiology, pathology and so on. The attitude as one stakeholder described that because you can work as a nurse at home, you can do it also in whatever other place and environment should be abandoned. From research on the international business world and multinational teamwork we learned that lack of cross-cultural competence is often the main factor of failures in teamwork. The stakeholders noticed that education to improve cultural knowledge and competence would be very valuable in multinational teamwork as well as teamwork training. From Multinational Military Medical Teams we know that they train in simulation e.g. communication, collaboration and team based problem solving. According to the stakeholders a positive attitude of the team members

and respecting of employers policies *and* skilful leadership are valuable tools in overcoming cultural differences and achieving effective multicultural team work.

All stakeholders felt very strong about the need for standardisation and agreement on procedures and policies in multinational work environment. The importance of standardisation was less stressed in the literature. The Aviation industry has found that standardisation of procedures has proven to be an effective strategy to reduces cultural differences and promoting teamwork. However one stakeholder in particular found that it can cause inner conflict if the strictness on following the provided policies prevents from delivering good care and limiting the nurse in using the nursing skills acquired during many years of working experience. Following the same policies and procedures can reduce the occurrence of professional conflict, but is not the “golden ticket” to good team work as can be heard from the experiences of the stakeholders on working in The Middle East.

The element of leadership wasn't (surprisingly) brought much to the attention in the literature that was reviewed. What was mentioned was mainly directed at leadership aimed at accomplishing a set professional task, rather than leadership towards cultural competed teamwork. From the interviews it was more clear that there is a need for leaders in teamwork. Leaders should have skills, tools and authority to ensure the proper behaviour not only professionally but also socially of all the team members. A reliable system for feedback that is competent to identify the true causes of non-effective multinational teamwork (and provide solutions!) does not exist at the moment according to the stakeholders, nor was it found mentioned in the literature.

A noticeable difference between literature review and interviews is the emotional input that accompanies the text in the interviews. When the discussion reached the issue of “what is not working in multinational team work” it became evident that when it is not working the effects can be quite traumatic for team members. In the literature review is mentioned e.g. “...disempowerment...feelings of discrimination, inequality, negative attitudes...” From the interviews can be found that “feelings” might be a somewhat mild description of what the impact of failing team work can be. As said earlier, re-

search data/literature that would provide detailed information of what the effects of failing multinational teamwork is on beneficiary and/or care provider (both employee as well as employer) couldn't be found by the author. Are the effects/outcome a matter of "hurt feelings" or could failing teamwork result in serious or permanent damage, and are there possible financial implications?

Cultural friction is mentioned several times, however the subjects causing cultural friction are not extensively or explicitly listed. The author noticed that e.g. ethnicity, sexual orientation or gender and how different team members might relate to these were not at all or hardly mentioned in the literature.

In literature is mentioning of ethical dilemmas in the context of professional identity/competence. In the interviews the ethical dilemmas were mostly mentioned in the context of cultural awareness / cultural friction and seem to be having serious impact on the functioning of the team member who is encountering ethical dilemmas. The stakeholders indicated that ethical dilemmas (involving own values, human rights or good nursing practice principles) are a recurrent reason for team members to return to work in a more familiar environment or a place where these ethical dilemmas are not present. However with the increasing mobility of healthcare workforce it is only a matter of time that also "at home" ethical dilemmas will arise and need to be discussed openly and dealt with.

10.2 Conclusions

In the literature review and interviews the challenges of multi-national teamwork for nurses consist of various elements summarized by the author in seven categories; multinational teamwork (teamwork promoting/inhibiting traits), cultural competence, cultural self-awareness, professional identity/competence, communication skills, respect and education.

The mentioned elements are not to be separated from each other, for effective multinational teamwork all elements are intertwined and play an important role. Need for edu-

cation in teamwork skills, communication skills and cultural competence for the team members are mentioned frequently in the reviewed literature and interviews.

Personality traits as cultural willingness, friendliness, flexibility, tolerance, diplomacy do have a high impact on the outcome of multinational teamwork. The question remains open if that and other personality traits can be learned or have to be taken in consideration in the professional choice/selection procedures.

The absence of mentioning of leadership in literature in the sense of leadership to overcome cultural friction and guidance towards cultural competence and effective teamwork needs further contemplation and is possibly an area for further studies.

Systematic working towards a cultural competent nursing workforce is highly recommended in the reviewed literature and interviews. How to achieve this is a matter that needs more empiric study and evaluation.

REFERENCES

- Alam, M. A. (2015). Cockpit learning in power distant cockpits: The interaction effect of pilot's interdependence and inclination to teamwork in airline industry. *Journal of air transport management*, 42, 192-202.
- Almutairi, A. F., Gardner, G., & McCarthy, A. (2013). Perceptions of clinical safety climate of the multicultural nursing workforce in Saudi Arabia: A cross-sectional survey. *Collegian*, 20(3), 187-194.
- Almutairi, A. F., McCarthy, A., & Gardner, G. E. (2015). Understanding cultural competence in a multicultural nursing workforce: registered nurses' experience in Saudi Arabia. *Journal of Transcultural Nursing*, 26(1), 16-23.
- Al Thobaity, A., Plummer, V., & Williams, B. (2016). What are the most common domains of the core competencies of disaster nursing? A scoping review. *International emergency nursing*.
- Arcada Patient Säkerhets- och Lärocenter (APSLC), GROW-file, unpublished data, 2013-2015. Accessed 8.9.2017
- Aveyard, H. (2014). *Doing a literature review in health and social care: A practical guide*. McGraw-Hill Education (UK). P. 15-18.
- Apker, J., Propp, K. M., Ford, W. S. Z., & Hofmeister, N. (2006). Collaboration, credibility, compassion, and coordination: professional nurse communication skill sets in health care team interactions. *Journal of Professional Nursing*, 22(3), 180-189.
- Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: a critical review. *BMC medical research methodology*, 9(1), 59.
- Barrett, M. (2007). Practical and ethical issues in planning research. *Research methods in psychology*, 24-48.

- Bowling, A. (2014). *Research methods in health: investigating health and health services*. McGraw-Hill Education (UK). Page 182-183.
- Brett, J., Behfar, K., & Kern, M. C. (2006). Managing multicultural teams. *Harvard business review*, 84(11), p. 84.
- Calvillo, E., Clark, L., Ballantyne, J. E., Pacquiao, D., Purnell, L. D., & Villarruel, A. M. (2009). Cultural competency in baccalaureate nursing education. *Journal of Transcultural Nursing*.
- Chang, W. W. (2007). Cultural competence of international humanitarian workers. *Adult education quarterly*, 57(3), 187-204.
- Chiu, Y. W., Weng, Y. H., Chen, C. F., Yang, C. Y., & Lee, M. L. (2014). Perceptions and efficiency of short-term medical aid missions among key groups of health professionals. *Evaluation & the health professions*, 37(3), 379-393.
- Clamp, C., Gough, S., & Land, L. (2005). Resources for nursing research. Retrieved from <http://ebookcentral.proquest.com/lib/diak/detail.action?docID=334525>
- Collin, K., Paloniemi, S., & Herranen, S. (2015). INPROF—promoting teamwork processes and interprofessional collaboration in emergency work.
- Cox, K. B. (2003). The effects of intrapersonal, intragroup, and intergroup conflict on team performance effectiveness and work satisfaction. *Nursing Administration Quarterly*, 27(2), 153-163.
- Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.. Page 55 – 57.
- Deng, F. F. (2015). Comparison of nursing education among different countries. *Chinese Nursing Research*, 2(4), 96-98.

Directive 2013/55/EU of the European Parliament and of the Council of 20 November 2013. Retrieved from: <http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32013L0055&from=EN>. Pdf

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis: A focus on trustworthiness. *Sage Open*, 4(1), 2158244014522633.

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of advanced nursing*, 62(1), 107-115.

Felemban, E., O'Conner, M., McKenna, L. (2014). Cultural view of nursing in Saudi Arabia. *Middle East Journal of Nursing*, volume 8 issue 4, 8-14

Finnish Advisory Board on Research Integrity. Retrieved from <http://www.tenk.fi/en/responsible-conduct-research-guidelines/introduction>. Last accessed 31.01.2017

Flick, U. (2009). Introduction to qualitative research. Retrieved from <http://ebookcentral.proquest.com/lib/diak/detail.action?docID=743651>

Gough, D., Thomas, J., & Oliver, S. (2012). Clarifying differences between review designs and meth-ods. *Systematic reviews*, 1(1), 28.

Greenhalgh, T., & Peacock, R. (2005). Effectiveness and efficiency of search methods in systematic reviews of complex evidence: audit of primary sources. *Bmj*, 331(7524), 1064-1065.

Health at a glance 2015 OECD indicators. Retrieved from: <http://apps.who.int/medicinedocs/documents/s22177en/s22177en.pdf>

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative health research*, 15(9), 1277-1288.

- Hsu, E. B., Thomas, T. L., Bass, E. B., Whyne, D., Kelen, G. D., & Green, G. B. (2006). Healthcare worker competencies for disaster training. *BMC Medical Education*, 6(1), 19.
- Hunt, M. R. (2008). Ethics beyond borders: how health professionals experience ethics in humanitarian assistance and development work. *Developing World Bioethics*, 8(2), 59-69.
- Johnson, J. P., Lenartowicz, T., & Apud, S. (2006). Cross-cultural competence in international business: Toward a definition and a model. *Journal of International Business Studies*, 37(4), 525-543.
- Jumat, J. D., Bezuidenhout, M. C., & Neethling, T. G. (2014). Pre-deployment preparation of military nurses of the South African National Defence Force for participation in peace support operations. *Curationis*, 37(1), 1-9.
- Kajander-Unkuri, S., Salminen, L., Saarikoski, M., Suhonen, R., & Leino-Kilpi, L. (2013). Competence areas of nursing students in Europe. *Nurse education today*, 33(6), 625-632.
- Katapodi, M. C., & Northouse, L. L. (2011). Comparative effectiveness research: Using systematic reviews and meta-analyses to synthesize empirical evidence. *Research and theory for nursing practice*, 25(3), 191-209.
- Katzenbach, J. R., & Smith, D. K. (1993). *The wisdom of teams: Creating the high-performance organization*. Harvard Business Press. P.41
- Kealey, D. J. (2004). Research on intercultural effectiveness and its relevance to multicultural crews in space. *Aviation, space, and environmental medicine*, 75(7), C58-C64.
- Kingma, M. (2006). *Nurses on the move: Migration and the global health care economy*. Cornell University Press. P. 13-15.

- Kumar, R. (2005). *Research Methodologies: a step-by-step guide for beginners*. 2nd. P.10. P 144-160.
- Lal, S., & Spence, D. (2016). Humanitarian Nursing in Developing Countries A Phenomenological Analysis. *Journal of Transcultural Nursing*, 27(1), 18-24.
- Leggat, S. G. (2007). Effective healthcare teams require effective team members: defining teamwork competencies. *BMC Health Services Research*, 7(1), 1.
- Lerner, S., Magrane, D., & Friedman, E. (2009). Teaching teamwork in medical education. *Mount Sinai Journal of Medicine: A Journal of Translational and Personalized Medicine*, 76(4), 318-329.
- Medical Corps International Forum (n.d.). Retrieved from <http://www.mci-forum.com/training-multinational-medical-teams-for-deployment/> last accessed 08.05.20
- Melymuka, K (2006). *Managing Multicultural Teams. Winning strategies from teams around the world*. Retrieved from: <http://www.computerworld.com/article/2553557/it-management/managing-multicultural-teams.html>. Last accessed 21-05-2017
- Miller, F. A., Christensen, R., Giacomini, M., & Robert, J. S. (2008). Duty to disclose what? Querying the putative obligation to return research results to participants. *Journal of Medical Ethics*, 34(3), 210-213.
- Moyce, S., Lash, R., & de Leon Siantz, M. L. (2016). Migration Experiences of Foreign Educated Nurses: A Systematic Review of the Literature. *Journal of Transcultural Nursing*, 27(2), 181-188.
- Musson, D. M. (2000). A proposal for the integration of behavioural research into international space station operations. In M. J. Bragg, & M. S. El-Genk (Eds.), *AIP Conference Proceedings* (Vol. 504, No. 1, pp. 148-153). AIP.

Noguchi, N., Inoue, S., Shimanoe, C., Shibayama, K., & Shinchi, K. (2016). Factors Associated with Nursing Activities in Humanitarian Aid and Disaster Relief. *PloS one*, 11(3), e0151170.

Phillips, L. R. F. (1986). *A clinician's guide to the critique and utilization of nursing research*. Appleton-Century-Crofts.

Piccolo, F. L., & Thomas, H. (Eds.). (2009). *Ethics and planning research*. Ashgate Publishing, Ltd.

Polit, D. F., & Beck, C. T. (2004). *Nursing research: Principles and methods*. Lippincott Williams & Wilkins. P. 55-61

Rafferty, A. M., Ball, J., & Aiken, L. H. (2001). Are teamwork and professional autonomy compatible, and do they result in improved hospital care?. *Quality in Health care*, 10(suppl 2), ii32-ii37.

Resnik, D. B. (2003). *From Baltimore to Bell Labs: Reflections on two decades of debate about scientific misconduct*.

Resnik, D. B. (2011, May). *What is ethics in research & why is it important*. *The national*.

Roberts, P., Priest, H., & Traynor, M. (2006). Reliability and validity in research. *Nursing standard*, 20(44), 41-45.

Robinson, S., & Griffiths, P. (2007). *Nursing education and regulation: international profiles and perspectives*.

Rumrill, P. D., Fitzgerald, S. M., & Merchant, W. R. (2009). Using scoping literature reviews as a means of understanding and interpreting existing literature. *Work (Reading, Mass.)*, 35(3), 399-404

Salminen, L., Stolt, M., Saarikoski, M., Suikkala, A., Vaartio, H., & Leino-Kilpi, H. (2010). Future challenges for nursing education—A European perspective. *Nurse Education Today*, 30(3), 233-238.

Shamoo, A. E., & Resnik, D. B. (2009). *Responsible conduct of research*. Oxford University Press. Page 5-6.

Seidel, John V. (1998) *Qualitative Data Analysis*, www.qualisresearch.com (originally published as *Qualitative Data Analysis*, in *The Ethnograph v5.0: A Users Guide*, Appendix E, 1998, Colorado Springs, Colorado: Qualis Research).

Suter, E., Arndt, J., Arthur, N., Parboosingh, J., Taylor, E., & Deutschlander, S. (2009). Role understanding and effective communication as core competencies for collaborative practice. *Journal of interprofessional care*, 23(1), 41-51.

Sutton, J. L., & Edelmann, V. (2005). *Leader and team adaptability in multinational coalitions (LTAMC): An international research project*. ARMY RESEARCH LAB FORT SILL OK HUMAN RESEARCH AND ENGINEERING DIR.

Suutarla, A., Axelin, A., Fagerström, L., Flinkman, M., Heikkinen, K., Jokiniemi, K., Korhonen, A., Kotila, J., Meretoja, R., Saunders, H. (n.d) *Country report: Advanced Practice Nursing (APN) in Finland* (n.d). Retrieved from:
https://international.aanp.org/Content/docs/ICN_APN_country_profile_Finland.pdf

The Bologna Declaration of 19 June 1999. Retrieved from: http://www.magnacharta.org/resources/files/BOLOGNA_DECLARATION.pdf

Van Vliet, A. J., & Van Amelsfoort, D. (2008). *Multinational military teams. Multinational Military Operations and Intercultural Factors*.

Willems, A., Waxman, B., Bacon, A. K., Smith, J., Peller, J., & Kitto, S. (2013). Inter-professional non-technical skills for surgeons in disaster response: A qualitative study of the Australian perspective. *Journal of interprofessional care*, 27(2), 177-183.

Wilson, L., Callender, B., Hall, T. L., Jogerst, K., Torres, H., & Velji, A. (2014). Identifying global health competencies to prepare 21st century global health professionals: report from the global health competency subcommittee of the consortium of universities for global health. *The Journal of Law, Medicine & Ethics*, 42(2_suppl), 26-31.

World Health Organization. (2009). *Global standards for the initial education of professional nurses and midwives*.

World Health Organization. (2013). *Transforming and scaling up health professionals' education and training: World Health Organization guidelines 2013*. World Health Organization.

WHO 2010. *WHO Global Code of Practice on the International Recruitment of Health Personnel*. Retrieved from: http://www.who.int/hrh/migration/code/code_en.pdf?ua=1

APPENDICES

Appendix 1.



AGREEMENT ABOUT COMMISSIONED DEGREE THESIS

STUDENT

Name Wilhelmina Anna van Vliet	Student ID number C34786
Address Pirttikatu 8, 20320 Turku - Finland	Phone number +358 44 2964832
Degree Programme Master's Degree of Global Health Care	
Specialisation option	

COMMISSIONING PARTY

Name Arcada University of Applied Science / <i>CROW-project</i>	Phone number +358 (0)207 699 699
Address Jan-Magnus Janssonin aukio 1, 00560 Helsinki - Finland	
Contact person Principal Lecturer H. Paakkonen	
A degree thesis is considered to be commissioned if there is a written agreement about at least one of the following (mark with a cross):	
<input type="checkbox"/> The commissioning party pays either Arcada or the student for the work. <input type="checkbox"/> The degree thesis has got a supervisor on the part of the commissioning party (external supervisor). <input checked="" type="checkbox"/> The commissioning party intends to utilise the results in its activity.	

DEGREE THESIS

Title: MULTINATIONAL TEAMWORK AND NURSES: Are Nurses prepared for the Challenges of Globalisation in Health Care in their Education? A Scoping Literature Review with Stakeholder Interviews	
Description of the degree thesis The purpose of the project is to investigate factors associated with nurses working in a multinational team in normal daily job, disaster aid or health mission. The aim is to collect data from literature and by interviews from which awareness for the possible need of multinational teamwork education could arise and ideas for nurse education on multinational teamwork can be constructed. The research question to be addressed: What are the challenges of multi-national teamwork? Is there a need for specific education on the subject of multinational teamwork for nurses?	
Work on the degree thesis begins 28.03.2017	The degree thesis is handed over to the commissioning party

CONFIDENTIALITY CLASSIFICATION

The following part of the degree thesis ought to be classified as confidential
Reason:
<input type="checkbox"/> The degree thesis contains information on inventions, new facilities, procedures or developments that can have commercial significance. <input type="checkbox"/> The degree thesis contains business secrets. <input type="checkbox"/> The degree thesis contains information on the actions of authorities classified as confidential as defined in the Act on the Openness of Government Activities (621/1999).
<i>NB! Classification as confidential is made only in exceptional cases. The decision is made by the Head of Department and Administrative Director of Arcada based on the submission of the student and supervising teacher.</i>

SUPERVISION OF THE DEGREE THESIS

Supervising teacher H. Paakkonen, RN, PhD
Supervisor on the part of the commissioning party

SIGNATURES

Place and date Helsinki, 30.05.2017		
Representative of the commissioning party 	Student 	Supervising teacher

LITERATURE REVIEW ARTICLES

1. Almutairi, A. F., Gardner, G., & McCarthy, A. (2013). Perceptions of clinical safety climate of the multicultural nursing workforce in Saudi Arabia: A cross-sectional survey. *Collegian*, 20(3), 187-194.
2. Almutairi, A. F., McCarthy, A., & Gardner, G. E. (2015). Understanding cultural competence in a multicultural nursing workforce: registered nurses' experience in Saudi Arabia. *Journal of Transcultural Nursing*, 26(1), 16-23.
3. Calvillo, E., Clark, L., Ballantyne, J. E., Pacquiao, D., Purnell, L. D., & Villarruel, A. M. (2009). Cultural competency in baccalaureate nursing education. *Journal of Transcultural Nursing*.
4. Chang, W. W. (2007). Cultural competence of international humanitarian workers. *Adult education quarterly*, 57(3), 187-204.
5. Chiu, Y. W., Weng, Y. H., Chen, C. F., Yang, C. Y., & Lee, M. L. (2014). Perceptions and efficiency of short-term medical aid missions among key groups of health professionals. *Evaluation & the health professions*, 37(3), 379-393.
6. Collin, K., Paloniemi, S., & Herranen, S. (2015). INPROF—promoting teamwork processes and interprofessional collaboration in emergency work.
7. Cox, K. B. (2003). The effects of intrapersonal, intragroup, and intergroup conflict on team performance effectiveness and work satisfaction. *Nursing Administration Quarterly*, 27(2), 153-163.
8. Felemban, E., O'Conner, M., McKenna, L. (2014). Cultural view of nursing in Saudi Arabia. *Middle East Journal of Nursing*, volume 8 issue 4, 8-14

9. Hsu, E. B., Thomas, T. L., Bass, E. B., Whyne, D., Kelen, G. D., & Green, G. B. (2006). Healthcare worker competencies for disaster training. *BMC Medical Education*, 6(1), 19.
10. Hunt, M. R. (2008). Ethics beyond borders: how health professionals experience ethics in humanitarian assistance and development work. *Developing World Bioethics*, 8(2), 59-69.
11. Jumat, J. D., Bezuidenhout, M. C., & Neethling, T. G. (2014). Pre-deployment preparation of military nurses of the South African National Defence Force for participation in peace support operations. *Curationis*, 37(1), 1-9.
12. Lal, S., & Spence, D. (2016). Humanitarian Nursing in Developing Countries A Phenomenological Analysis. *Journal of Transcultural Nursing*, 27(1), 18-24.
13. Noguchi, N., Inoue, S., Shimanoe, C., Shibayama, K., & Shinchi, K. (2016). Factors Associated with Nursing Activities in Humanitarian Aid and Disaster Relief. *PloS one*, 11(3), e0151170.
14. Suter, E., Arndt, J., Arthur, N., Parboosingh, J., Taylor, E., & Deutschlander, S. (2009). Role understanding and effective communication as core competencies for collaborative practice. *Journal of interprofessional care*, 23(1), 41-51.
15. Willems, A., Waxman, B., Bacon, A. K., Smith, J., Peller, J., & Kitto, S. (2013). Interprofessional non-technical skills for surgeons in disaster response: A qualitative study of the Australian perspective. *Journal of interprofessional care*, 27(2), 177-183.
16. Wilson, L., Callender, B., Hall, T. L., Jogerst, K., Torres, H., & Velji, A. (2014). Identifying global health competencies to prepare 21st century global health professionals: report from the global health competency subcommittee of the consortium of universities for global health. *The Journal of Law, Medicine & Ethics*, 42(2_suppl), 26-31.

Appendix 3.

INTRODUCTION LETTER FOR INTERVIEW STAKEHOLDER

Dear Stakeholder,

Thank you for giving your time for this interview.

Currently I am a student enrolled in “Master Degree Program of Global Health Care” provided by ARCADA, DIAK and BARATON University/Kenya. Writing a Master’s Thesis is part of this study program. My Thesis is commissioned by ARCADA/GROW project.

The title of my thesis is “*Multinational Teamwork and Nurses: Are Nurses prepared for the Challenges of Globalisation in Health Care in their Education? A Scoping Literature Review with Stakeholder Interviews.*”

The aim and purpose are “*to investigate factors associated with nurses working in a multinational team in normal daily job, disaster aid or health mission and to collect data from literature and by interviews from which awareness for the possible need of multinational teamwork education could arise and ideas for nurse education on multinational teamwork can be constructed.*”

The research questions are: “*What are the challenges of multi-national teamwork for nurses and is there a need for specific education on the subject of multinational teamwork for nurses?*”

In this interview I am interested to hear your expert opinion on the above mentioned issues. There is no questionnaire, but I do have a few questions written down with the intention of interview guide.

- What are the challenges of multinational teamwork in your experience?
- Where you prepared for these challenges at any point of your nursing career?
- In your opinion: What seems to be working in the current way of doing multinational teamwork and why?
- In your opinion: What is not working in multinational teamwork, could this be corrected and if so, how?

The interview and gathered data will be handled to the guidelines of The Finnish Advisory Board on Research (Tutkimuseettinen neuvotellukunta TENK). The ethical concepts and principles such as honesty, integrity, trust, accountability, respect, confidentiality and fairness, will be respected by the researcher. The participant in the interview can withdraw from participating at any time. Confidentiality is assured. Recorded and transcribed data will be destroyed after use. In the text the interviewed will be referred to as “stakeholder (1), (2) or (3)”